DOCUMENT RESUME

ED 119 429 EC 081 559

AUTHOR	Folsom, Geneva S.
TITLE	Life Skills for the Developmentally Disabled: An Approach to Accountability in Deinstitutionalization. Volume II: Manual for Trainers.
INSTITUTION	George Washington Univ., Washington, D.C. School of Medicine.
SPONS AGENCY	Rehabilitation Services Administration (DHEW), Washington, D.C. Div. of Developmental Disabilities.n
PUB DATE	[75]
GRANT	51-P-15436/3-01
NOTE	110p.; For the other two documents in this series, see EC 081 558, 560; Some pages may reproduce poorly in hard copy due to small print of original
AVAILABLE FROM	Dr. Geneva S. Folsom, The George Washington Univ., Div. of Rehabilitation Medicine, Washington, D.C. 20037 (Training Materials, prices vary)
EDRS PRICE	MF-$0.83 HC-$6.01 Plus Postage
DESCRIPTORS	Daily Living Skills; Educational Accountability; Exceptional Child Education; Handicapped Children; *Institutes (Training Programs); Program Descriptions; Recordkeeping; Residential Programs; *Staff Improvement; *Teaching Guides
IDENTIFIERS	*Deinstitutionalization; *Developmental Disabilities

ABSTRACT

A trainer's manual is presented in the second of three volumes on the Life Skills for the Developmentally Disabled Project, which focuses on deinstitutionalization through improved staff utilization. It is explained that the manual provides strategies designed to involve the total staff and clients in a system of accountability for communicating, setting goals together, and monitoring record-keeping procedures. Lesson content in the form of discussion questions, suggested responses, group process procedures, and experiential exercises is provided for the following issues: basic concepts and responsibilities of accountability, use of the Adaptive Behavior Scale, attitudes toward deinstitutionalization, the superintendent's role, the team approach, attitude therapy (a systems approach to consistent communication with clients), and use of the Problem-Oriented-Record. Seven appendixes include related papers by Roland J. Queene, "The Superintendent and Accountability," and Richard L. Burke, "Dimensions of Managerial Behavior." (CL)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED119429

VOLUME II

LIFE SKILLS FOR THE DEVELOPMENTALLY DISABLED

An Approach to Accountability in Deinstitutionalization

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

(Hospital Improvement Program - Community Alternatives and Institutional Reform, Project Number: 51-P-15436/3-01)

MANUAL FOR TRAINERS

GENEVA S. FOLSOM, Ed.D.
Project Coordinator

Funded by Department of Health, Education and Welfare, Social Rehabilitation Services Administration, Division of Developmental Disabilities, Region III, and administered by Division of Rehabilitation Medicine, Department of Medicine, School of Medicine and Health Sciences, The George Washington University, Washington, D.C., in cooperation with the University Affiliated Facility for Child Development, Georgetown University, Washington, D.C., the District of Columbia Developmental Disabilities Council, and Forest Haven, District of Columbia's Institution for the Developmentally Disabled.

EC081353

VOLUME II: MANUAL FOR TRAINERS

LIFE SKILLS FOR THE DEVELOPMENTALLY DISABLED
An Approach to Accountability in Deinstitutionalization

TABLE OF CONTENTS

I. ACKNOWLEDGEMENTS i

II. INTRODUCTION

A. The Life Skills Project 1
B. Objectives of Training Manual 4
C. Instructions for Use of Training Manual 5
1. General 5
2. Selection of Classroom Instructor 6
3. Format of Training Sessions 7

III. ISSUES AND STRATEGIES FOR ACCOUNTABILITY IN THE DEINSTITUTIONALIZATION PROCESS

ISSUE NO. 1. Who's Going to Be Accountable in Training for Deinstitutionalization? 9
STRATEGY NO. 1. Everyone – Including the Client 9

ISSUE NO. 2. Where Do We Start in The Deinstitutionalization Process? 17
STRATEGY NO. 2. With Some Form of Evaluation of Functioning in Life Skills Areas 17

ISSUE NO. 3. What's the Name of the Game? 26
STRATEGY NO. 3. Understanding Your Own Attitudes Toward Deinstitutionalization 26

ISSUE NO. 4. What's the Role of the Coach? 33
STRATEGY NO. 4. Initiating Deinstitutionalization Plays 33

ISSUE NO. 5. What Position do I play? 38
STRATEGY NO. 5. Set Up Team Approach – All Positions are Important 38

ISSUE NO. 6. How Do We Keep Our Signals Straight? 52
STRATEGY NO. 6. Establish a Consistent Communication System 52

ISSUE NO. 7. What Kind of Equipment Do I Need for This Game? 71
STRATEGY NO. 7. Use the Life Skills Rehabilitation Section of the Problem-Oriented-Record (P.O.R.) 71

ISSUE NO. 8. How Do We Keep Score in This Game? 86
STRATEGY NO. 8. Establish an Accountable Record Keeping System 86

IV. APPENDICES

A. Answer Sheet to Pre-Post Tests 90
B. "The Superintendent and Accountability" – Roland J. Queene, M.Ed. 90
C. "Dimensions of Managerial Behavior," and "Explanations of Styles of Influence" – Richard L. Burke, Ph.D. and Philip G. Hanson, Ph.D. 96
D. "Guidelines for Leadership Role in Rehabilitation Team" – Geneva S. Folsom, Ed.D. 101
E. "Steps for Administering and Scoring the Adaptive Behavior Scale" – Jean Federici, Field Instructor 102
F. Task Forces 104
G. Training Model Slide 104

I. ACKNOWLEDGEMENTS

A team effort was essential in this approach to developing a training model for accountability in deinstitutionalization. Mrs. Jean Federici, Field Instructor for the project, was assigned full-time to Forest Haven.* Her skills in the roles of liaison, teacher, team meetings coordinator, and communicator par excellence were invaluable to the success of the project.

Mrs. Betsy Sessions, part-time staff assistant, was indispensible in planning, organizing, scheduling, and communicating between the Project, Forest Haven, and Task Force Members. Miss Myra Feldman, illustrator for training materials, contributed to the success of the training package by possessing skills needed to translate a concept into a visual symbol. Her ability to communicate via illustrations provided a framework for the total training package. Special appreciation also goes to Ms. Janette D. Breen who came into the project at the ninth inning and helped prepare it for publication.

Mr. Roland Queene, Superintendent of Forest Haven, made it possible for us to develop this particular model for training. Without his total cooperation, philosophy of leadership, and goals for accountability in deinstitutionalization, we would have been extremely limited in our approach. He was not only generous with his own time and cooperation, but allowed us to work as part of his managerial team. We have worked closely with Forest Haven staff, particulary staff in Transitional Services under the direction of Mr. Willie Hodge, Assistant Superintendent. Miss Frances M. Greene, Training Officer, helped us set the pace for instituting the Life Skills Approach by giving us priority for scheduling and assisting in staff development. Mrs. Regina Wintermeyer, Assistant Superintendent for Facility and Community Programs, and Mr. Dave Burket, Chief, Habilitation Services, implemented programs we initiated. Mrs. Roma Kaplan, Director of Voluntary Services, added volunteer help to our project. Mr. Phil Slabaugh, our full-time volunteer since January, has augumented potential for instituting our training programs. Line staff has also been extremely cooperative and helpful in giving us feedback and suggestions on staff development efforts. We have listened carefully and have incorporated feed-back from many people. We are indebted to all staff at Forest Haven. This model has been developed in an institution which is in process of change toward deinstitutionalization. Because of their assistance, we believe this model can be helpful to any institution moving from a medical to a developmental model or from an institutional to a client-centered approach.

We have also relied heavily on our Task Forces to help recommend training materials which will assist clients adjust in the community. We considered this group as representative of that part of the community which will be vitally involved with clients as they move from an isolated rural setting to the inner city. We "brain-picked" our consultant, Dr. John Noone, who was able to give input from the University Affiliated Facility (UAF), Georgetown University, Washington, D.C., as well as his own expertise in the process of deinstitutionalization. The resources of the Rehabilitation Training Center at The George Washington University were also tapped. Initially, Dr. Wayne Sloop, Unit Director at Lynchburg Training School

---

*Institution for the Developmentally Disabled – Washington, D.C., Laurel, Maryland

and Hospital, Lynchburg, Virginia, and later, Mrs. Mary Jane Billinger, Chief of Education and Training at Northern Virginia Training Center, Fairfax, Virginia, served as resource persons for our initiation to the P.O.R. (Problem-Oriented-Record). They served as sounding boards as we moved through our model for deinstitutionalization. Since all three institutions are involved in some aspect of the deinstitutionalization process, this interchange has been most meaningful. By working together we could avoid time-consuming mistakes and refine our model while we developed it.

We appreciate the efforts of Dr. Donald E. Hawkins, Project Director, Susan Tinker, and Elizabeth J. Kiser, in assisting us with evaluation of our final product. We also note the editorial assistance of Ms. Susan Swannack Nunn and the additional secretarial assistance of Nadine Dombrowski, who worked in true team fashion under publication dead-line pressure.

Geneva S. Folsom, Ed.D.
Coordinator
Life Skills Project

A. The Life Skills Project*

The Life Skills Project was funded by Social Rehabilitation Services (SRS) through the George Washington University School of Medicine for a one-year period beginning July 1, 1974. The funding was granted to assist Forest Haven, D.C.'s institution for the developmentally disabled in their efforts at providing a target population with those Life Skills necessary for successful assimilation into the D.C. area. Although the development of work habits has been emphasized with this population, little effort has been concentrated on developing self-help skills and wise use of leisure time which are vital if the deinstitutionalized person is to cope successfully in a less structured environment.

Our first priority was to fit the goals of the project to the overall needs of the institution. We operated on this principle, and when the needs of the institution changed we obtained permission to qualify the grant in accordance with changing priorities. The grant, as originally written, called for training staff involved with clients in process of deinstitutionalization and those who would need institutionalization. Since the administration set deinstitutionalization as their first priority, we asked to concentrate on this target population rather than spread our efforts to both groups. By adapting to these changes, we feel our accountability for training staff and clients in Life Skills concepts was an important component in helping to reach the goals set by the institution.

In order to be accountable we felt our training model should insure continuity after the project was completed. A major criticism of grants has been that they may be effective while in operation but all gains for the institution vanish with project completion. By training instructors we feel we have built in a continuing staff development program. As part of the grant proposal, Forest Haven and Lynchburg Training School and Hospital exchanged training programs. We also included Northern Virginia Training Center in this team approach to sharing programs and staff. We have been able to avoid some duplication of effort and we have been able to learn about their problems in instituting the P.O.R. Any programs that are duplicated in nearby institutions will make client transfer more effective.

A major strategy of the training model is to utilize clients as models and instructors for those Life Skills they have developed. Clients are assigned as supervisors, instructors, or students in various Life Skills areas (for example, grooming, telling time, handling money, etc.).

One full-time member of the project staff was assigned full-time to Forest Haven. The success of the project was dependent upon Mrs. Jean Federici, Field Instructor. She followed through with indirect training on a one-to-one basis with direct-care staff. In this way training initiated at a conference or administrative team level was reinforced at the working level.

---

*Rewritten from Geneva Folsom, Ed.D., "The Staff and Their Responsibilities," *Deinstitutionalization: A Service Continuum.* (Published by Developmental Disabilities Council of West Virginia and Virginia in cooperation with Region III, HEW Developmental Disabilities Council Consortium, February 1975), pp. 80-87.

Selected Forest Haven staff will serve as instructors in the future. They are being trained to replace project staff at the conclusion of the formal project. The impact of our project may be evidenced by the fact that the director of voluntary service assigned a full-time volunteer to our project. This has expanded our capability for follow-through and ward-level training. The use of clients as instructors will probably prove to be our most vital link in training, since the final accountability for success in deinstitutionalization is the clients' own involvement in the process.

One of the expressed needs of the institution at the beginning of the project was improved staff communications. The project served as a catalyst in this area, much in the same way that any outside force can have impact in opening communications. The training package in Life Skills was designed to assist with the communication problem, and all evaluations, models, etc., within the project were designed to be used as devices to open communication so that the focus would be upon the client rather than upon maintaining the status quo of the institution. We began by reinforcing the team concept which had just been introduced in the areas in which we are working.

As part of the model training program we introduced basic ideas of participatory management (team approach). We introduced staff to various leadership styles and to the use of Team Approach as a management device for fully utilizing *all* staff to be accountable in meeting specified goals for the client. In setting up training sessions where management and staff work together on common goals, we are beginning to see the effect of improved working relationships through improved client behaviors. The indirect effect of improved communication will evidence itself through any changes observed on pre and post-test scores on the ABS (or any similar Life Skills evaluation instruments).

Another means of showing accountability for the project will be the direct measurement of change in pre and post-tests of the client population through the use of the Adaptive Behavior Scale (ABS). We used the revised ABS to establish a baseline on present functioning in the Life Skills areas because the revision of the ABS tests Life Skills areas both for the institution and the community. In order to obtain two ratings we instructed the counselors and teachers in the administration of the ABS. This helped insure accuracy and opened up avenues for discussion, since there had been some controversy between teachers and counselors regarding client functioning. The staff who had most direct contact with clients were put into Mini-Teams so they could exchange information, decide on priorities for training, and begin to break down communication barriers. This is also another means of establishing accountability. Those who are involved in decision-making are more likely to be involved with building in success for their proposals. By working together each will be aware of the goals for the client. Goals can be set according to individual areas of expertise and availability of training materials, but awareness of all goals can help with reinforcement throughout the system. The client, too, is involved from the beginning so that he/she knows his/her strengths and deficiences and participates actively in goal-setting.

From our initial testing with the ABS, we found areas which tested low because of lack of opportunity for development in the institutional setting. Items such as *initiative, public*

transportation, and *eating in public* scored low because there had been no opportunity for clients to practice these Life Skills. Changes within the institution were initiated to help overcome these gaps; for example, knives and forks are now being provided so clients will have opportunity to practice eating with these utensils.

Accountability to each other and to the client is emphasized through another communication device, *Attitude Therapy*. This framework for staff communication was developed at the Menninger Clinic in the 1940's. The system is used by staff to help promote consistency of approach toward clients. The success of deinstitutionalization efforts depends upon changing staff concepts of their basic mission. Whereas they were formerly valued and praised for their efforts toward keeping clients in a protective environment, they are now asked to teach clients those skills they will need to succeed in the outside world. This means staff must change from being "helpers" and "keepers" to "facilitators." The *Attitude Therapy* framework can be most helpful because it is a systems approach to responding in a common way to client behaviors. Through learning these *"Attitudes,"* staff can be attuned to more appropriate ways of responding according to client needs. *Attitude Therapy* provides a framework which allows staff to change their own behaviors without feeling unduly threatened. Emphasis is placed upon instructing staff in the *Matter-of-Fact Attitude* which places accountability for change on the client.

One goal of the project was to assist Forest Haven in their institution of the Problem-Oriented-Record System in order to provide accountability in record-keeping. Through the development and use of the Rehabilitation Section of the Life Skills Project, Forest Haven is now instituting the total P.O.R. system. Since the Rehabilitation Section was designed to give decision-mkaing to direct care staff, we seem to have overcome many of the resistances encountered in other institutions who have gone to this system of accountability in record-keeping.

Finally, our efforts toward accountability are directed toward involvement of outside agencies in this project. The initial grant developed from a conference on Life Skills held at George Washington University early in 1974. At that time representatives from the D.C. area participated in sharing their work in Life Skills areas. Using that group as a nucleus for Task Forces, we kept those people actively involved in this project. We added new members as we heard of other agencies and individuals working in the same direction. We divided the larger group into smaller working Task Forces so they could meet as groups and exchange ideas and training materials. The project serves, again, as a catalytic agent by pulling people and materials together to meet a common need. Through the utilization of Task Forces we are keeping eighteen District of Columbia and two state agencies apprised of our programs and training methods. All of these agencies can be utilized as links in the outreach chain to the community. By involving them early, this should help with the preparation of the community for discharged clients. This two-way flow of information should also help insure full utilization of resources within the District of Columbia and immediate state areas.

The full impact of the Life Skills Project may be found in the summary of the training report. We utilized nine people as instructional staff, exposed eighteen local agencies, two

half-way houses, and two state agencies to the Life Skills concepts; and offered 764 training experiences to staff at Forest Haven, eighteen agencies represented on the Task Forces, and to key staff at Lynchburg Training School and Hospital. We introduced a cooperative training program with Northern Virginia Training Center for supplementary training in P.O.R. In response to a request from their training director, *Attitude Therapy* was introduced to their staff. As some of these common communication devices are used throughout the area, transferability of clients through institutions and transitional agencies should be more successful, since follow-through will be facilitated by better communication. Final accountability for the project will be determined by the dissemination and use of Life Skills training materials and concepts within the Region III purview.

B. Objectives of Training Manual

The overall goal of this Manual for Trainers is to present a developmental approach to accountability in the process of normalization. All strategies for meeting this goal are designed to involve the total staff and clients in a system of accountability for communicating, setting goals together, and monitering record-keeping to insure that goals and objectives are being met. Although this system is devised to meet these goals for an institutional setting for the developmentally disabled, the same system will be appropriate for any setting in which clients are institutionalized. Clients adapt the Life Skills they need to exist in institutions. Once they have adapted to any institutional way of life, they need to learn new Life Skills which will give them a meaningful life outside the institution. For those who will always need some protected setting, the system is designed to help them develop the skills they need for the most independent functioning possible.

This developmental approach includes five objectives:

1. Inclusion of client in his/her own program of deinstitutionalization. The ultimate goal of the staff development training model is to utilize clients as "instructors" for other clients. Use of the Mini-Team is the primary strategy for improving communications between those most familiar with the client and for involving the client in the normalization process.

2. Establishment of a system of objective measurement so staff can assess the level of functioning of the client in Life Skills areas. As a strategy to achieve this objective, the Adaptive Behavior Scale (ABS) is administered to find the baseline and set goals and objectives for assisting clients improve levels of functioning.*

3. Building a system of accountability where goals and objectives of training are clearly stated, accountability for working toward goals clearly assigned, and credit for change duly recorded. This is accomplished through the Life Skills Rehabilitation Section of the Problem-Oriented-Record (P.O.R.).

---

*Any similar broad Life Skills evaluation instrument may be used (See Issue #2, p. 2.)

4. Improvement of communication within the institution and in the community. To achieve this objective, two strategies are utilized: (a) Team Approach, to insure full utilization of all staff as trainers and models for clients; and (b) *Attitude Therapy*, a means of promoting consistency in staff communication with clients.

5. Development of training materials which assist trainers in teaching staff the skills, attitudes, and knowledge necessary for the Life Skills approach to deinstitutionalization. These training materials will be prepared for (a) all staff who come in direct contact with the clients and (b) clients themselves in the form of Objective Charts.

C. Instructions For Use of Training Manual

1. General

The training manual is written as a guide for presenting the Life Skills Approach to accountability in the deinstitutionalization process. It may be used as: (1) a basic course in deinstitutionalization concepts at the university level; (2) a core course for staff development within a facility; and (3) as self-instructional materials for persons with appropriate backgrounds. Once an instructor is selected, this manual could be used as self-instructional material for the classroom instructor and then as the training manual for introducing the concepts to field instructors.

Six major concepts are presented: (1) *Inclusion of the client* in the training model; (2) Use of the *Adaptive Behavior Scale* (ABS) as the rehabilitation guide in life skills areas; (3) Use of the *Problem-Oriented-Record* (P.O.R.) as a system of accountability for programming and monitoring; (4) *Team Approach* for full utilization of all staff as members of the rehabilitation team; (5) *Attitude Therapy* for consistency of approach toward the client and for helping change staff attitudes from a custodial or medical model to an educational model; and (6) *Life Skills* Rehabilitation Section of the P.O.R. which includes training material for staff and clients. Each of these major concepts is presented with a series of slides which can be used as guidelines for discussion. For the purposes of this publication, these slides have been reproduced in the text. (See Order Blank for Slides.)

The classroom instructor will need to arrange training time and format relevant to the sophistication of the group to be trained. Concepts presented in the trigger slides may be used as a new approach or as a review. The total package may be divided into learning modules; for example, one credit hour can be allotted for each major concept. The field instructor would supervise the practicuum which should accompany each concept presentation.

This training package is designed to be used with multi-disciplinary groups. It should never be presented solely for one group such as nursing assistants, or social workers, etc. Each of the concepts is selected to fortify and augment the Team Approach. It is essential that all of those who are to be in the same working environment be trained together. The multi-disciplinary team approach will be reinforced through multi-disciplinary training sessions. Discussions and experiential exercises are designed to promote communication and team cohesiveness. Many of the problems of communication within a system may be solved through the medium of the training sessions.

Effectiveness of the Life Skills Approach depends upon total involvement of all persons within the learning environment at an institution, transitional agency or in the home. Managerial support is the first prerequisite for success of the approach. It may be very revealing and useful for management to identify its own receptiveness to the concepts presented in this deinstitutionalization program. Direct-care workers may be more enthusiastic than management about democratic management and shared decision-making. Usually, larger numbers of direct-care people than professionals will need to be trained, but experience has shown that mixed-groups training sessions are most effective. In any case, all persons involved directly or non-directly in care of the developmentally disabled need to be trained, and the training period itself can become a good introduction to the Team Approach technique of management. Working with mixed groups enhances the educational process by the pooling and expressing of diverse viewpoints.

2. Selection of the Classroom Instructor

Good communication is the key to successful management of all concepts chosen for the Life Skills approach to deinstitutionalization. The time and effort required to carefully select an instructor will significantly enhance the initial investment. Potential instructors should be selected from those who really enjoy working with the developmentally disabled, who believe that the custodial institution is not the ideal place for spending ones life, who believes that the developmentally disabled can grow and change despite a grim diagnosis, who believes that all people are entitled to a meaningful life, and who believe that everyone in the environment, including the clients, should be members of the "treatment" team. The pre-test on Attitudes Toward the Developmentally Disabled can be a valuable tool in this selection process. Choose someone who already has a good attitude toward the developmentally disabled and toward deinstitutionalization concepts. Because the instructor will be the model for helping others to incorporate new attitudes and ideas, selection of a negative instructor will only invite failure for any new program.

Other things being equal, select a person who will not be afraid to deal with feelings. The instructor will be confronted with various attitudes and prejudices and (s)he must allow *full* expression of diverse views and be able to elicit maximum participation of group members. At the same time, the instructor must exercise skillful controls to retain the focus of training. In short, the ability to communicate effectively, freely, and openly, and to guide group dynamics with sensitivity and patience should be the primary qualifications of any person selected as instructor.

The instructor should be sensitive to the particular needs of the institution or facility in which this approach is implemented. If the leadership has already instituted a dynamic philosophy and program geared toward deinstitutionalization concepts, the instructor may want to omit or de-emphasize the section on the role of the superintendent (leader). If the Team Approach is a way of life, it may not be necessary to use this training strategy. The instructor should not, however, make independent judgements of the use or omission of any of these strategies. After finding a baseline through the Pre-Tests for each Strategy Section, results may indicate there is no need for further instruction, and the section may be omitted or just briefly reviewed.

In essence, the instructor should be flexible and innovative in using any training materials. The particular sequence of training as outlined in this Manual was instituted because of an expressed need for better communication within this particular institution. The Manual is designed around a philosophical tenent: First you open up communications. Then you plan programs – together. This philosophical tenent was formulated after 20 years of watching grand programs going down the drain because the designer didn't deem it necessary to involve the "troops."

3. Format For Training Sessions

1. Administer pre-test.

2. Show slides as indicated in manual.

   a. Use slide to elicit discussion.

   b. Follow discussion and cover primary concepts, but do not let this limit the discussion. Record and add answers to suggested responses.

3. Present experiential exercises designed for each slide or set of slides.

4. Observe group process during discussions. Follow guidelines suggested in training manual. Use staff member skilled in group process to direct this phase of each training session, although delegating assignment to other trainees may give them valuable experience. Utilize feed-back and evaluation to emphasize and reinforce Team Approach.

5. Assign suggested reading to reinforce learning experience in class. If you are training instructors, suggested reading should be assigned, reviewed, and discussed.

6. At the beginning of each session, review slides used at previous session, to insure a developmental process in training sequence.

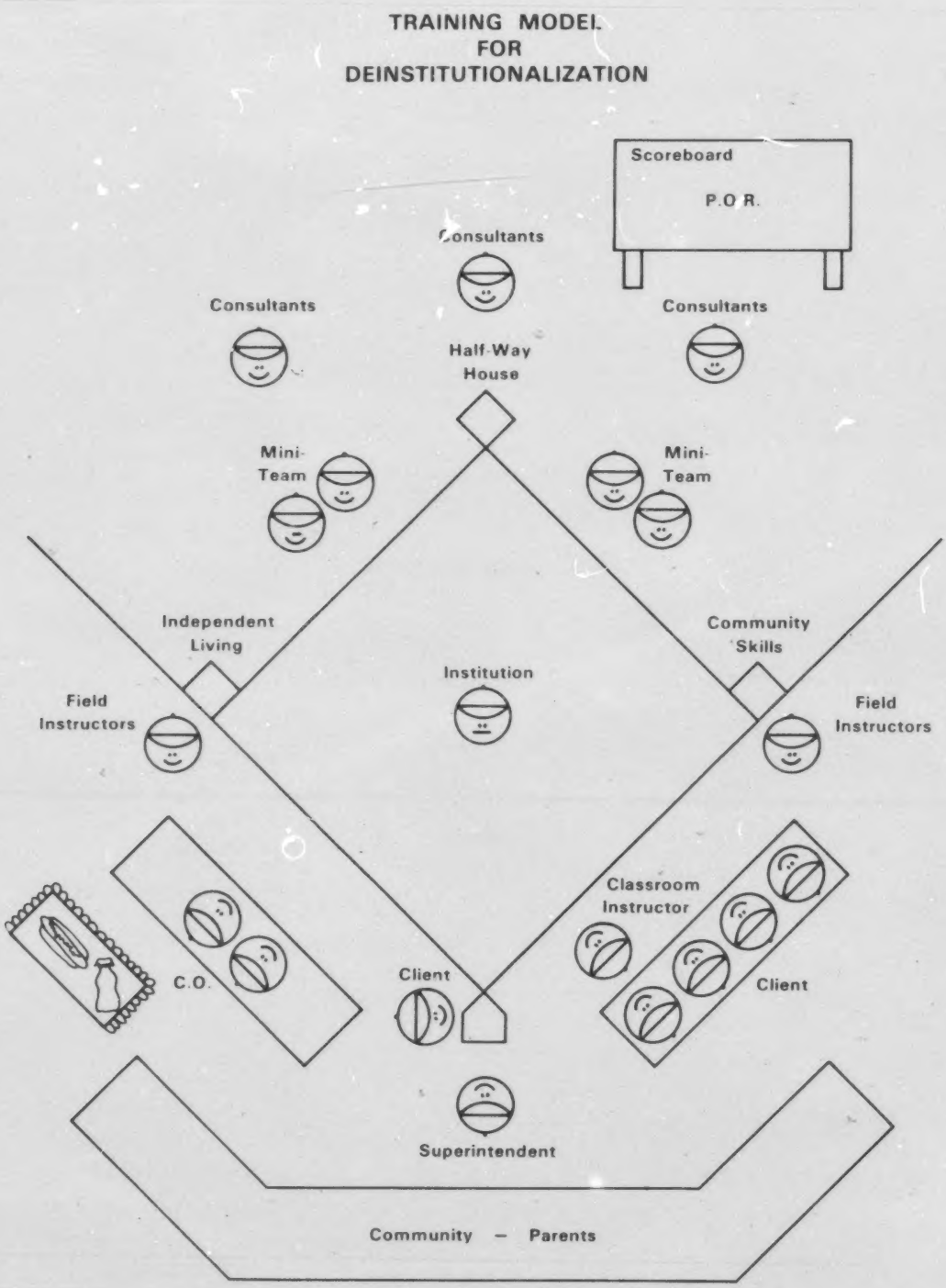
7. Administer post-test. Compare results.

III. ISSUES AND STRATEGIES FOR ACCOUNTABILITY IN THE DEINSTITUTIONALIZATION PROCESS

ISSUE NO. 1. WHO'S GOING TO BE ACCOUNTABLE IN TRAINING FOR DEINSTITUTIONALIZATION?

STRATEGY NO. 1. EVERYONE – INCLUDING THE CLIENT

Show slide: No. 1-a – "Model for Training in Life Skills Approach"*



*See Appendix G

1. Discussion	Suggested Responses
What is the role of the Classroom Instructor in this training model for deinstitutionalization?	The Classroom Instructor is the Manager in this training model for deinstitutionalization. The Manager plans the strategies for training in deinstitutionalization concepts. The Manager makes the game plan for training toward accountability in deinstitutionalization. The Manager is in charge of the team on the field (the Field Instructors). The Manager is accountable for how the training team performs. If the team is not "scoring" (training staff so that clients make home runs into the community), the Manager must review, revise, and reconstruct training strategies. The Manager is a teacher and role model for the deinstitutionalization training team. The Manager exposes the teaching team to the deinstitutionalization concepts and demonstrates how the plays can be made.
Where does training take place in this model?	On the playing field. In this case, the playing field includes the institution, the out-reach agencies, the family units, and the community. The Field Instructors may be trained in a classroom situation within the institution, or in an academic setting tied to the institution. There must be constant flow of communication between the classroom and the field if the initial training takes place in a more formal classroom setting.
What is the role of the Field Instructor in this model?	The Field Instructors are the base coaches. They are the real key to the immediate play. They are watching the clients and staff as they interact in the game (deinstitutionalization). The Field Instructor (base coach) is aware of impending problems and helps staff prepare clients before they get up to bat. The Field Instructor helps the Deinstitutionalization Team by teaching concepts on the spot. The Field Instructor implements the strategies designed to win the game for the Deinstitutionalization Team. The Field Instructor makes sure staff is incorporating the deinstitutionalization goals set in initial training.

What are the advantages in having Field Instructors (base coaches)?

They are there when the plays occur.

They provide a follow-through system in training from classroom to field.

They can assist learning in the area in which it is most likely to occur in the real life situation.

They can serve as action researchers.

They can give immediate feed-back to the players.

They can give immediate reinforcement to positive players.

They are intimately involved with the players.

They can see the immediate plays from a better vantage point than the Manager.

They can give feed-back to the Manager so (s)he can keep current on research for new plays.

Should the Classroom Instructor (Manager) be part of the institutional/facility staff?

There are advantages to the Classroom Instructor being *outside* the institution:

The "outside" instructor does not become as entangled in the internal politics and machinations of the organization (or home).

The "outside" instructor can remain more objective. This is particularly important when you are teaching concepts that are anxiety-producing. It is difficult to remain objective when you are worrying about your next pay-check.

The "outside" instructor is non-threatening to staff. Staff can express strong opinions without fear of retaliation by someone in the system or the system itself. Outsider can be fearless and deal with issues that are too threatening for staff to open up.

The "outside" instructor can bring in a fresh outlook and is not burdened with too much historical knowledge of the institution or family. (S)he is not caught up in working-day details and can assess from a broader viewpoint. (S)he can drain the swamp instead of fighting off alligators.

The "outside" instructor has not developed opinions re the capabilities of the staff and clients. (S)he has no pets nor axes to grind.

The "outside" instructor can serve as a rallying point for staff as they solidify their own group. This can be very helpful for the staff – and very distressing to the uninitiated instructor.

Are there any advantages to the Classroom Instructor being employed within the institution?	The "inside" instructor might be more readily available for consultation. The "inside" instructor should know staff and clients better. The "inside" instructor can keep closer contact and communication with Field Instructors. The "inside" instructor may have a better understanding of the total training needs of staff and clients.
Who is the most important player in this training model?	The batter – the client. All staff training is structured to focus on the needs of the client, to help structure learning experiences so the client will develop those skills needed to make an adjustment toward more independent living.
Does the client have any role in modeling and training other clients?	*Of course.* As one "batter" is up, the others are waiting in the dug-out. They have been in preparation for their turn at bat. They observe the successes of the batter. They learn by watching his/her performance.
Why do the bases have different captions?	This illustrates the developmental sequence to the acquisition of Life Skills. To get to first base, staff must help clients acquire Life Skills needed for community living. Many of these skills can be acquired within an institution, if the institution provides the opportunities for learning. The first step is to recognize that the client will need certain skills (A.B.S.). Second base marks a half-way point to independent living; for example, this may be a half-way house, group home, or any semi-protected environment in the community. In this training model, third base is home in the community. Once the client has acquired those skills necessary for independent living, (s)he has successfully completed the deinstitutionalization process.
What are the advantages to setting up intermediate goals for out-reach from the institution?	It breaks down the ultimate goal of deinstitutionalization into more realistic objectives. It provides a way-station for learning opportunities in more realistic settings. It provides continuity of service from the institution. It gives opportunity for success along the way – opportunities for positive reinforcement for staff and clients. For some clients, first, second, or third base may be the ultimate goal. However, this places the emphasis on "becoming" rather than on permanent placement.

	It gives staff opportunity to become integrated into the community.
	Both staff and client become part of the system of change toward normalization.
Once the client is living independently in the community, is there any role for the institution?	Yes. The institution should be a focus for contact, follow-through, and maintenance of relationships as long as the client needs some support system. In this way, the institution itself can serve as a consultant to other resources in the community rather than as a direct care giver.
Why does Central Office get a box seat in this training model for deinstitutionalization?	They set policy and pay for programs that lead toward deinstitutionalization. They are vitally important as active observors to progress toward change. They watch the scoreboard for successes. They "own" the team. If the team is winning, they will invest in its future.
Where is the Community in this process of training for deinstitutionalization?	In the bleachers. Rooting for the team. Watching and supporting good plays. "Booing" for bad plays. Supporting the entire normalization effort.
What is the role of the institution (or family) in the training for deinstitutionalization?	In this training model, the institution is the pitcher. Whereas in the old custodial model, the institution expected the client to just catch the balls they threw, in this model the pitcher expects the client to respond by hitting, by scoring. It's up to the pitcher to throw the balls (problems) so the batter can score. As the Manager changes the style of the game, the pitcher has to respond.
What is the role of the Superintendent (leader in this training model?	The Superintendent is the umpire.
	The "umpire" starts and stops the game of training for deinstitutionalization.
	The "umpire" has the final say about training.
	The "umpire" allows training to occur.
	The "umpire" does not tell the Manager how to do the training, but (s)he makes decisions on how the game is performed.
	The "umpire" can call the game, post-pone the game, call for time-outs according to progress being made in training toward normalization.
Who are the Consultants?	Consulting staff includes management and "professional" personnel.

Why are the Consultants playing out-field?

In this training model, management and "professional" staff are viewed as consultants for direct-care staff, the Mini-Team (in-fielders).

They are playing out-field because they are needed to back up the in-field when they reach their limits in training for deinstitutionalization.

The in-field players are more intimately involved with the first action. There are fewer occasions for the out-fielders to come into motion in this training model.

The majority of plays in teaching Life Skills can be handled in the in-field. When it cannot be solved here, the out-field is brought into play.

The out-fielders serve as role models for the clients and Mini-Teams. They are visible; they are competent; they have expertise needed when the occasion arises; they are supportive of the Mini-Team and client efforts.

The consultants are part of the action in this model. They are on the field *with* the client, community, umpire, and in-field players. They come into "play" when the client needs assistance. They respond to the client rather than having the client respond to them.

In this model, the consultants are aware of the total action as well as the individual client. They can be more supportive of the "team" concept. They are not "above" or "on top of the game." They are performing with the rest of the participants.

What is the Mini-Team in this model?

The Mini-Team is that small group of people who work most closely with the client in the process of deinstitutionalization.

Is there any set pattern for composition of this Mini-Team?

No. This grouping may change according to the client and his/her needs. It may also change according to the setting. If the client is on first base, the Mini-Team might be composed of the counselor/direct care staff and/or a teacher and employer.

Is the client part of this Mini-Team?

Absolutely. As the client rounds the bases toward normalization, there are frequent communications with the Mini-Team re the plays, the successful hits, the grounders, the fly balls, the bunts, the strike-outs, and the home runs. The Mini-Team is observing the client in action, rewarding for positive plays, coaching when necessary. The client is the one who makes the moves. The Mini-Team analyzes the plays and keeps the client moving forward in the field.

Why is it essential to form Mini-Teams in this model of training?	To increase frequency and quality of communication among those nearest the client.
	To keep the client totally involved in his/her individual treatment (game) plan.
	To put decision-making at the level where the players are most intimately involved.
	To put goal-setting with those who are most interested in meeting goals and objectives.
	To help make this team sensitive to each other's needs.
	To facilitate exchange between and among agencies. For example, if Vocational Rehabilitation is concentrating on development of good work habits, that counselor should be part of the Mini-Team so that the reinforcement system will help the client reach the next base more efficiently.
	To simplify problem-solving. Problems are solved in the context in which they appear. They are part of the on-going process, not removed from reality. Those needed for problem-solving are readily available.
When will we need the entire Team for decision-making?	When the Mini-Team needs extra guidance, assistance, expertise for problem-solving, information, back-up, support, "clout" for policy-making, setting of overall goals and objectives, and game directions.
What does inclusion in the training model do for the client?	Breaks down old patterns of institutionalization. Leads client toward active involvement rather than passive acceptance.
	Helps establish firm relationships between client and staff. These relationships are often tenuous in an institution. Clients have minimum of privacy and tend to form shallow relationships because of this.
	Assists in increasing contacts with outside world as community participants are included. For example, the Mini-Team may want to include a volunteer from a church in the community where the client is going to live. This first contact could provide a link in the deinstitutionalization process.
	Provides a social experience on an adult level. The experience of participating as a member of the team will provide a unique learning experience.

Assembles staff and client in a more realistic way. If they are problem-solving together, this tends to bridge the gap between their usual roles which socially isolate them from each other.

Gives him/her an opportunity to view successes. Sets up means of building from successes rather than failures.

Places client in situation where (s)he must consider and take part in planning immediate and long-range future. In most institutions this is often overlooked; therefore (s)he becomes resigned and depressed.

Places him/her in a situation where (s)he must plan realistically; (s)he cannot resort to world of fantasy. Through mutual inspection of strengths and weaknesses, (s)he can draw more realistic conclusions re his/her place in the outside world. If you hit a home run, it's visible. If you strike out, you look at what you did and plan another strategy.

Places him/her in a situation which is designed to improve self-image. (S)he is identified as a participant – not someone in the bleachers or "left" field!

What is the role of the client in the "dug-out?"

Just as the batter is a model for those warming up, the "dug-out" represents that group in an institution or facility who are most nearly ready to move to the next stage of development in the normalization process. Others who are less prepared see this selected group as the "successes," the next in line to "graduate," the ones who have learned the skills necessary to make a more independent adjustment.

Is this a new role for clients?

No. Clients have always modeled behavior for each other. In this training model we have attempted to structure the modeling so that skills of independent living are valued rather than skills of existing passively within an institution. Rather than learning to "beat the system," clients are reinforced for learning to join the system and grow toward living in a less restricted environment.

How do we keep score in this game?

With the Life Skills Rehabilitation Section of the Problem-Oriented-Record (P.O.R.). See Issues No. 7-8.

Suggested Reading: "Retarded Persons as 'Teachers': Retarded Adolescents Tutoring Retarded Children." Patricia Wagner and Manny Sternlicht, American Journal of Mental Deficiency 1975. Volume 79, No. 6., pp. 674-679.

Surveyor Training Manual for Institutions for Mentally Retarded: Bureau of Quality Assurance, Health Series Administration, PUblic Health Service, Department of Health, Education and Welfare 1975, p. 101.

ISSUE NO. 2 WHERE DO WE START IN THIS PROCESS?
STRATEGY NO. 2. WITH SOME FORM OF EVALUATION OF FUNCTIONING IN LIFE SKILLS AREAS (We chose the Adaptive Behavior Scale (ABS)).

A. Pre-Post Test On Adaptive Behavior Scale

Instructions: Fill in appropriate column with a check-mark (✓).

	True	I think so	I don't know	False
1. The A.A.M.D. Adaptive Behavior Scale is a behavior rating scale for mentally retarded, emotionally maladjusted, and developmentally disabled individuals.				
2. For purposes of accountability in deinstitutionalization, the A.B.S. is more appropriate than an I.Q. test.				
3. The A.B.S. will help staff describe an individual's daily functioning in broad life areas.				
4. Part One of the A.B.S. measures skills in independent functioning, economic activity, vocational activity.				
5. Part Two of the A.B. S. measures maladaptive behavior.				
6. If the person ranks in the upper percentile on Part One of the A.B.S., that person is probably ready for good adjustment in the community.				
7. The A.B.S. can help us pin-point problem areas and provide framework for appropriate programs of remediation.				
8. We can write an individual treatment plan from the A.B.S. or use the results to develop behavioral norms for M.R. population grouping.				
9. The A.B.S. has a built-in evaluation process based on measured change of behavior over time.				

Scoring: See Appendix A

B. Introduction

A major problem in communication within any institution or facility which helps train the developmentally disabled, is that of finding measurements which assist staff in being objective ré their clients. This is a particular problem in "custodial" institutions which have used the I.Q. scale or clinical diagnosis as a basis for placement and programming. Although the I.Q. and diagnosis are helpful in many ways, they do not give us a picture of the functioning level of the person tested. I.Q. gives us an idea of the range of "academic" functioning we might expect, but current research indicates even this is misleading. We have underestimated the levels of functioning in the Life Skills area because we have limited our thinking with I.Q. assessment.

The AAMD Adaptive Behavior Scale (A.B.S.) has gained wide acceptance as a scale that assesses an individual's ability to function in society. According to the A.B.S. Manual:

> The AAMD Adaptive Behavior Scale is a behavior rating scale for mentally retarded, emotionally maladjusted, and developmentally disabled individuals, but can be used with other handicapped persons as well. It is designed to provide objective descriptions and evaluations of an individual's adaptive behavior. The term "adaptive behavior" was introduced and defined by the American Association on Mental Deficiency in the first editions of its Manual on Terminology and Classification in Mental Retardation and retained in the new revision. The term primarily refers to the effectiveness of an individual in coping with the natural and social demands of his or her environment.

The A.B.S. was chosen as the primary evaluation instrument for this Life Skills Project because it evaluates skills in the broad life areas: independent functioning, physical development, economic activity, language development, numbers and time, vocational activity, self-direction, responsibility, socialization, and maladaptive behavior.* In order to establish a system of communication involving objective measurement of a client's functioning level and skills, we can utilize the A.B.S. in every way suggested in the A.B.S. Manual. We can identify areas of deficiency for both individuals and groups. We can provide an objective basis for comparison of an individual's ratings over a period of time. This provides a system of accountability which can follow the client out of or into an institution or any other setting where continuing training will be needed. We can use the A.B. S. to help with the Team Approach by structuring the Mini-Team as the focus for setting priorities in meeting objectives in rehabilitation areas. Whereas previously there may have been disagreements between teachers and cottage counselors on client functioning levels, they can now both rate and compare the individual in the same Life Skills areas. The agreement or discrepancies between ratings provides the basis for problem-solving at Mini-Team meetings.

The A.B.S. ratings provide common grounds for evaluation. We can now look at ratings between school and cottage as well as between teacher and counselor. We can send the A.B.S. to be scored at other agencies where clients are placed. For example, the Vocational Rehabilitation Counselor can obtain an A.B.S. rating at the sheltered workshop. Then we have a comparison between the institution and vocational placement. In this project, the A.B.S. has served as the major stimulus for direct individual programming, and as the base for the Life Skills Rehabilitation Section of the Problem-Oriented-Record. Because of the success of this approach to programming, the managerial team extended the Life Skills Program throughout the institution. The clients can be tested with the A.B.S. and placed according to their functioning levels. This replaces the politics, guesswork, and subjective judgements in placement and transfer of clients to various units or out-reach programs. It is a communication system based on objective measurement. It measures the functioning level of the client at this point in time and begins where the client is - not where the client was.

Bogen and Aanes note usefulness of the A.B.S. as a tool in program evaluation and report the scale has strong implications for rehabilitation programs. An abstract of their article summarizes the rationale for our selection of the A.B.S. as a primary tool in improving communications:

> "The A.B.S. is proposed as a useful tool to identify programmatic needs in a Mentally Retarded (M.R.) population. The A.B.S. lends itself to the process of developing behavioral norms for M.R. population grouping. These behavioral norms are then utilized to objectively determine individual and group programmatic needs. The

---

* Any instrument which evaluates these Life Skill domains could be used as the major evaluation instrument. See: BCP Observation Booklet. Developed by the Office of the Santa Cruz County Superintendent of Schools, 1973. Special Education Management Systems (SEMS). Palo Alto: VORT Corporation, 1973.

system allows the development of priorities, short and long term goals, based upon normative peer grouping. The system has a built-in evaluation process based on measured change in behavior over time."

Suggested Readings: D. Bogen and D. Aanes, "The A.B.S. as a Tool in Comprehensive M.R. Programming." Mental Retardation (February 1975).

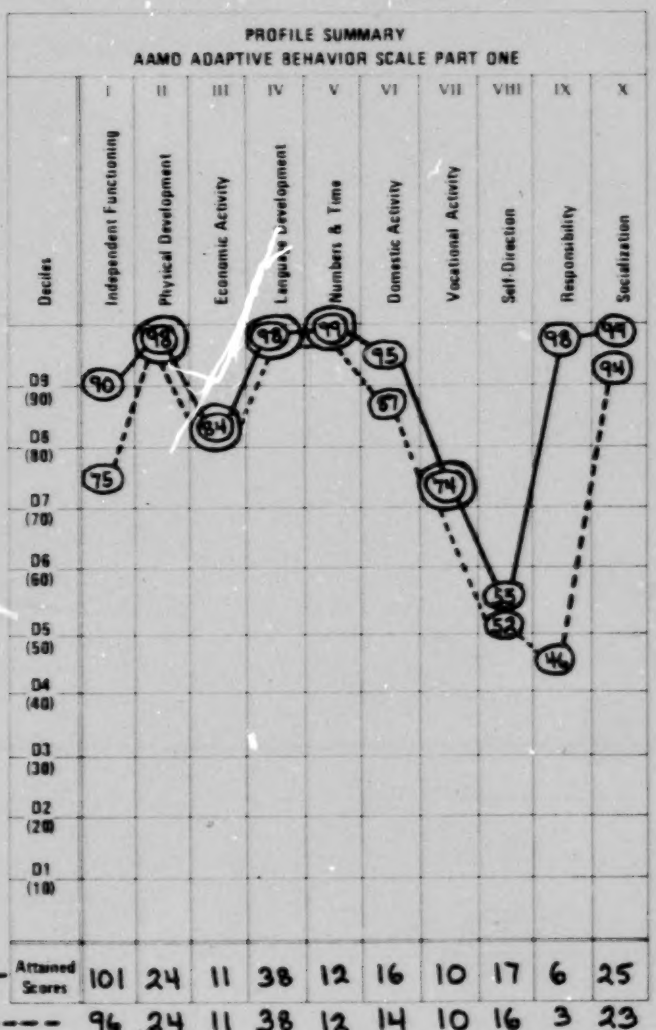
Kazuo Nihara, Ray Foster, Max Shellhass, and Henry Leland, AAMD Adaptive Behavior Scale: Manual. Revised edition. (Washington, D.C.) Association on Mental Deficiency, 1974).

Dennis Bogen and David Aanes, "The A.B.S. as a Tool in Comprehensive M.R. Programming." Mental Retardation (February 1975). p. 38.

C. Primary Concepts

Show Slide No. 2-a: "Profile Summary - AAMD Adaptive Behavior Scale: Part One"

Identification Sue Jefferson
Age 35
Sex F
Date of Administration July 15, 1975



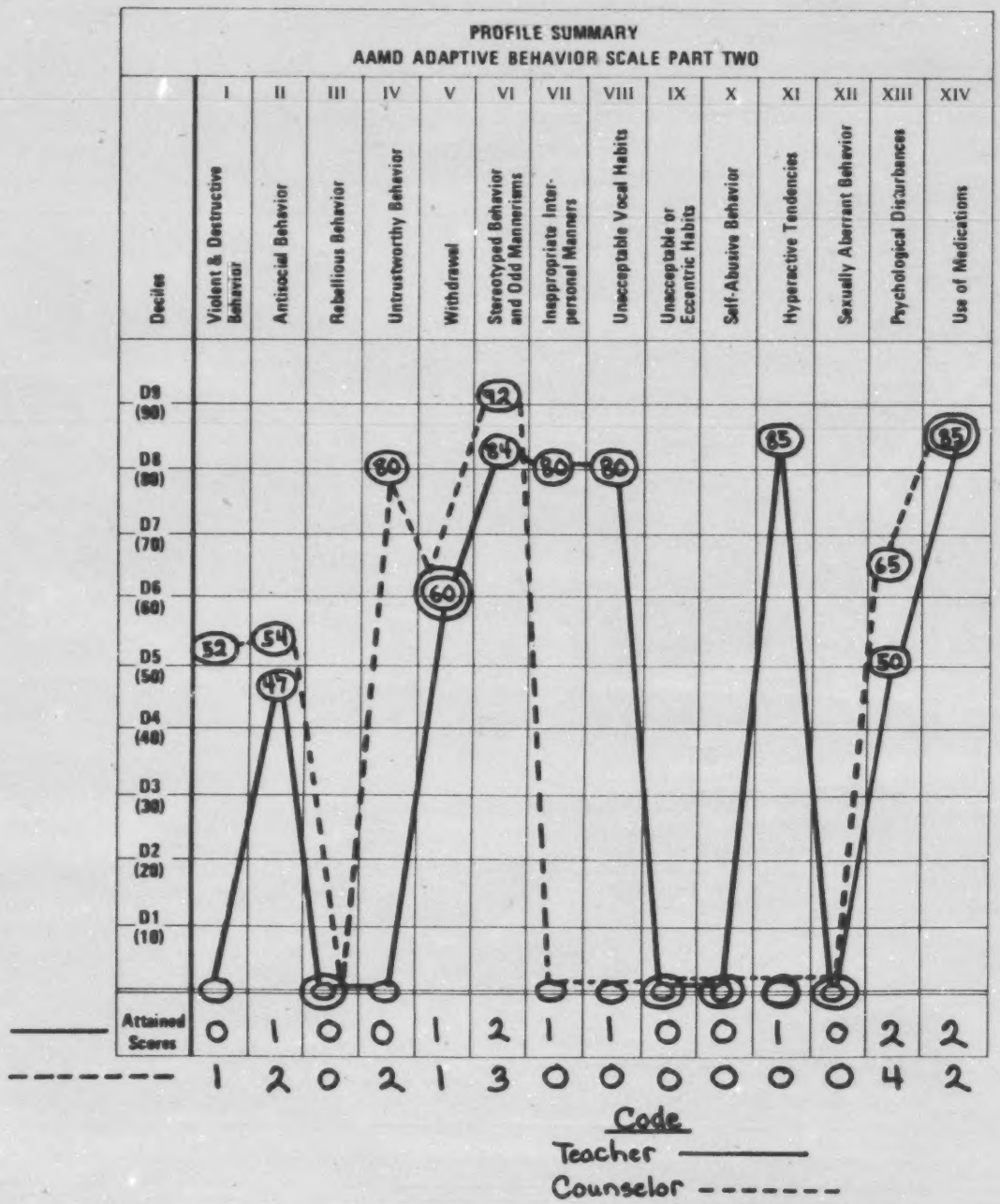
Code
Teacher ————
Counselor - - - - - - - -

1. Discussion:	Suggested responses:
What is the advantage of having two ratings for each client?	It gives a more accurate profile. It points out discrepancies in how the same person may be viewed differently by different staff members. It points out discrepancies which may reveal the client behaves differently in different situations. It gives the client a broader perspective of how others view his/her behavior. It brings communication out into the open. It provides a structured point of departure for problem-solving in Mini-Team meetings.
Who should administer the A.B.S.?	At least two persons who have the most knowledge of the client. Those who spend the most time with the client. In an institution this may be direct-care worker and the teacher or the employee if the client works or is in vocational training. If the client is living at home it is the parent. If the client is in a day-care center or group home, it would be the staff member most directly involved in day-to-day contact.
Should these profiles be administered according to his/her behavior in the past?	No! Look at current client vehavior. Rate according to how client is functioning right now. You are establishing a baseline for *present* functioning.
What information can you get from the profile?	A general idea of the functioning level. Scores at the top of the profile Part One indicate the client has mastered those particular Life Skills. This gives you guidelines for reinforcing success with the client. For example, "you scored high in numbers and time - that's good." It gives you a baseline for programming. It gives you guidelines for structuring your facility. Those areas which were scored low because the client lacked opportunity can be built into programming.
How can you share this with the staff and client?	After administration of A.B.S. by at least two persons, use results as guide for Mini-Team meeting. Include client in meeting. (S)he may have been included in administration of A.B.S. and this is opportunity for feed-back. Depending upon verbal abilities of client, results should be explained. If client disagrees with ratings, this can be opportunity for client to advocate for him/herself. Explanation of the results should first focus on positive. After staff and client have been "rewarded" for accomplishments in various Life Skills areas, priorities may then be set for working with lower areas.

How does Mini-Team set priorities for problem-solving?	Look at all low scores. Decide what is primary in deinstitutionalization process. For example, if client is working but cannot be placed in community because (s)he does not know how to budget money, this would be chosen as priority target for training. Do not pick more than two or three areas at once. There is some over-lap, but each time priorities are set, they should be within this framework. This narrows goals so they seem obtainable for both staff and clients.
What is connection between A.B.S. and Life Skills?	Domains and sub-domains of A.B.S. *are* Life Skills. Although the A.B.S. was originally developed for institutional use, it has been revised to be applicable in a community setting. It may be presumed if these Life Skills have been developed, the person can make a satisfactory adjustment in the "outside" world.
What are Life Skills areas in Part One?	Go over these from slide No. 2-a. Fill in with sub-domains or pull these from group discussion: Independent Functioning, Physical Development, Economic Activity, Language Development, Numbers and Time, Domestic Activity, Vocational Activity, Self-Direction, Responsibility, Socialization. Use A.B.S. forms for discussion. If you have already administered the A.B.S., use actual scales. Structure classes into Mini-Teams so they are familiar with clients being discussed.

Show Slide No. 2-b: Profile Summary - AAMD Adaptive Behavior Scale: Part Two

Identification Sue Jefferson
Age 35
Sex F
Date of Administration July 15, 1975



1. Discussion:	Suggested Responses
Is Profile interpreted in same way as that for Part One - high scores mean skill is well developed;	No - just the opposite. All behaviors in the domains are negative behaviors; therefore, a high score indicates unacceptable behavior.
How important are discrepancies on Part Two?	Extremely important. Part Two deals with client behaviors. This is an area in which staff attitudes and value systems become involved. "Aberrant" behavior to one person might not be "aberrant" to another. For example, see domain III - Rebellious Behaviors. Rater One is a cottage counselor. In the cottage, counselor sees client as being quite rebellious. Rater Two, a teacher, sees client as demonstrating rebellious behavior approximately one out of three times. Crucial question becomes: Why, in this setting, is the client being rated as much more rebellious? What is happening in this setting? What are the contingencies for this "rebellious" behavior"? Are all counselors viewing this client as "rebellious," or is this a personal struggle with one counselor and one client? Is this *usual* behavior or is the counselor reporting from one incident which occured three years ago? One other area which causes problems is area XII - Sexually Aberrant Behavior. The teacher, employer, and professional staff may never see this - because of lack of opportunity. The cottage counselor will have more opportunity to observe. Then the issue becomes one of deciding what is "normal" for an institution, in the real world, or for area in which client is living.
How do we set priorities for Part Two?	Look at behavior which is *most* aberrant. Person may rate very high in Antisocial Behavior. However, person is working and living in half-way house. If, however, this person "needs watching with regard to sexual behavior," (s)he is in danger of losing his/her job.
Can A.B.S. be administered by staff who are *not* sophisticated in evaluation instruments;	Yes. As instructor you need to be thoroughly familiar with instruments. You may want to call upon a consultant - someone who is familiar with psychological assessment. You should teach all levels of staff how to administer and score A.B.S. You will be using it as a continuous evaluation instrument. The Life Skills Rehabilitation component of the P.O.R. is based on A.B.S.

D. BIBLIOGRAPHY

Allen, R.M., Cortazzo, A.S., Adams C. "Factors in An Adaptive Behavior Checklist for Use with Mental Retardates", Training School Bulletin, Volume 67 (November (1970), pp. 144-157.

Bogen, D., Aanes, D. "The ABS as a Tool in Comprehensive MR Programming." Mental Retardation, (February 1975), pp. 38-41.

Foster, R., Foster, C. "The Measurement of Change in Adaptive Behavior." Paper presented at the Region V meeting of the American Association on Mental Deficiency. Wichita, Kansas, October 1967.

Foster, R., Nihira, K. "Adaptive Behavior as a Measure of Psychiatric Impairment." American Journal of Mental Deficiency, Volume 74 (1969), pp. 401-404.

Greenwood, D., Perry, R. "Use of the Adaptive Behavior Check-list as a Means of Determining Unit Placement in a Facility for the Retarded." Paper presented at the meeting of the Rocky Mountain Psychological Association. Denver, Colorado, May 1968.

Individualized Data Base Manual of Reports, IDB Publication Series, No. 5, January 1974.

Leland, H., and Smith, D. Mental Retardation: Perspectives for Tomorrow. Worthington, Ohio: Charles Jones, 1974.

Leland, H., Nihira, K., Foster, R., Shellhaus, M., and Kagin, E. Conference on Measurement of Adaptive Behavior: II, Parsons State Hospital and Training Center. Parsons, Kansas, 1966.

Libby, B.C. "Reliability and Validity of the ABS." Unpublished manuscript. Taribault State Hospital, Minnesota, 1973.

Malone, Daniel, and Christian, Walter. "Adaptive Behavior Scale as a Screening Measure for Special-Education Placement." American Journal of Mental Deficiency, Volume 79 (1974), pp. 367-371.

Nihira, K., Foster, R., Shellhaus, M., and Leland, H. "Adaptive Behavior Scales." Washington, D.C.: American Association of Mental Deficiency, 1969.

Nihira, K., and Shellhaus, M. "Study of Adaptive Behavior: Its Rationale, Method, and Implication in Rehabilitation Programs." Mental Retardation, Volume 8 (1970), pp. 11-16.

Nihira, K., Foster, R., Shellhaus, M., and Leland, H. AAMD Adaptive Behaviors Scale: Manual, 1974.

"Profiling Adaptive Behavior: A Computerized Approach." IBD Publication Series, Number 4, November 1973.

Watson, P.D., Quattlebaum, L.F., and Christian, W.P. "Computerized Application of the AAMD Adaptive Behavior Scale in a Large Hospital Setting." Paper presented at the Southeast Regional Convention, American Association of Mental Deficiency. Tampa, December 1971.

ISSUE NO. 3 WHAT'S THE NAME OF THE GAME?
STRATEGY NO. 3 UNDERSTANDING YOUR OWN ATTITUDES TOWARD DEINSTITUTIONALIZATION.

A. Pre-Post Test on Deinstitutionalization

Read the following statements. These are statements you often hear at work. (You also hear these statements at home -- substitute "boss" for "mom," or "dad," or "my kids.") Identify how frequently you hear these statements at work.

		Frequently	Often	Occasionally	Rarely
1.	"You don't understand these people."				
2.	"Administration won't buy it."				
3.	"Let's try it."				
4.	"I'll make this decision."				
5.	"It won't work - we've already tried it."				
6.	"We don't know what's going on."				
7.	"Let's get the client in this meeting."				
8.	"We don't have enough money."				
9.	"We don't have enough staff."				
10.	"It's against regulations."				

1. **Scoring:** For questions No. 1,2,5,6,8,9,10 score as follows:
   Frequently = 4; Often = 3; Occasionally = 2; Rarely = 1

   For questions No. 3,4, and 7, count scores as follows:
   Frequently = 1; Often = 2; Occasionally = 2; Rarely = 1

   Average the scores.

2. **Interpretation:**

Average score	= 3.5 to 4.0	You need all the help you can find on deinstitutionalization.
	= 3.0 to 3.5	You are in need of help if deinstitutionalization is to take place.
	= 2.5 to 3.0	You are resistant to change -- probably about average.
	= 1.0 to 2.5	You are well on the road to incorporation of deinstitutionalization concepts. You can selectively choose staff who may need this type of training.

Source: Department of Medicine and Surgery, Veterans Administration, adapted from Killer Phrases: Individual and Group Effectiveness Training: A Handbook for Trainers, Washington, D.C. June 1973, p. 77.

Answer Sheet for Scale MRAS *

No. 2. Please read your statements on the next two pages. Circle the response on this answer sheet. Do not use the statement pages. Please answer how you *feel* about these items. There are no right or wrong answess. Your responses will be given a code number and will not be identified with your name.

1.	A	B	C	D	E
2.	A	B	C	D	E
3.	A	B	C	D	E
4;	A	B	C	D	E
5.	A	B	C	D	E
6.	A	B	C	D	E
7.	A	B	C	D	E
8.	A	B	C	D	E
9.	A	B	C	D	E
10.	A	B	C	D	E
11.	A	B	C	D	E
12.	A	B	C	D	E
13.	A	B	C	D	E
14.	A	B	C	D	E
15.	A	B	C	D	E
16.	A	B	C	D	E
17.	A	B	C	D	E
18.	A	B	C	D	E
19.	A	B	C	D	E
20.	A	B	C	D	E
21.	A	B	C	D	E
22.	A	B	C	D	E
23.	A	B	C	D	E
24.	A	B	C	D	E
25.	A	B	C	D	E
26.	A	B	C	D	E
27.	A	B	C	D	E
28.	A	B	C	D	E
29.	A	B	C	D	E
30.	A	B	C	D	E
31.	A	B	C	D	E
32.	A	B	C	D	E
33.	A	B	C	D	E
34.	A	B	C	D	E
35.	A	B	C	D	E
36.	A	B	C	D	E

Source: University of Wyoming, Department of Psychology, A Final Report on Hi-Swat (January 1973).

Pre-Post Test on Attitudes Toward the Developmentally Disabled (2)

KEY

A	B	C	D	E
Strongly Agree	Somewhat Agree	Neither agree nor disagree	Somewhat Disagree	Strongly Disagree

1. People who are retarded should be sterilized so they cannot have children.
2. If one member of a family is retarded other members of the family are probably also retarded.
3. Parents who have a retarded child would be wise to have no further children.
4. Persons who drink a lot and are alcoholic have more retarded children than do non-drinkers.
5. Any person can have a retarded child.
6. A person who is normal can later become retarded from some types of illness.
7. Generally, we can pick out the retarded child by his physical appearance and his vacant, empty look.
8. Poor people have more retarded children than people who are well off.
9. Some disease such as measles, when the mother is carrying the child can cause retardation in the child.
10. A retarded child can love his parents as much as a normal child.
11. The mentally retarded child requires less love and attention than the normal child.
12. Mentally retarded children are as pleasant as the normal child.
13. The retarded child is as hurt by unkind and nasty remarks as much as the normal child.
14. Generally, retarded children have very different social and personal needs than the normal children.
15. Mentally retarded people cannot learn.
16. A great number of mentally retarded people are insane.
17. Many mentally retarded people can hold down jobs.
18. Mentally retarded people cannot be trusted because they are undependable and stupid.
19. Mentally retarded children are over-sexed.
20. It is generally not a good idea to let normal children play with retarded children.
21. Mentally retarded children have sexual interests.
22. The retarded child can feel pain as much as the normal child.
23. The retarded child should be treated more strictly than the normal child.
24. Retarded children always act silly.
25. All mentally retarded people should be put in institutions.
26. Schools should have education programs for the retarded.
27. The retarded child does not mind being dirty as much as the normal child.
28. Retarded people can hold jobs in the community.
29. Early training of the retarded child can help him become a good citizen.
30. Retarded children learn best when they fear the teacher.
31. The retarded child is more difficult to manage and control than the normal child.
32. Generally, it is wiser to keep the retarded child in the community than to send him to an institution.
33. Most people do not like to work with the retarded person.
34. It is the responsibility and duty of the schools to have training programs for the retarded.
35. Employers should hire retarded persons for jobs they can do.
36. Some retarded people can have successful marriagees.

B. Introduction

You have just investigated your own attitudes toward concepts of deinstitutionalization or normalization. Reward yourself if you have a healthy attitude toward normalization. If there is room for improvement you can excuse it for now because you are part of your institution.

Under ordinary circumstances, we can almost assume that any institution in existence over ten years will be a good candidate for deinstitutionalization of staff. Considering our bureaucratic proclivities, we might even be a bit suspect after an "institution" has been established for anything over a year. If you have the feeling that there are too many traditions in your facility or home, you might inspect the concrete in which it has been set. If it is beginning to harden, your facility might need deinstitutionalization (see score on Check-list for Deinstitutionalization).

If you have staff who say, "Let's try it; I'll make this decision; Let's get the client in this meeting," you have staff who feel secure, capable, and non-threatened. You have a staff who feel they have been allowed to be part of the system. They feel they are backed by management so they can try new things. They can be flexible. They can be decision-makers. They can be client-centered in their work. They are not caught in a system of dehumanization where no one moves without "permission." They are not caught in old roles suitable for a custodial institution but inappropriate, if not devastating, to progress in making all staff accountable to the client first, and the institution second.

In spite of lip service to the functions and contributions of lower-level personnel to direct patient care, we have made creeping advancement from the old roles which provide little in the way of true job satisfaction. In a discussion concerning ways of motivating employees, Herzberg says that "the growth or motivator factors that are intrinsic to the job are: achievement, recognition for achievement, the work itself, responsibility, and growth or advancement." These factors are listed as primary causes of job satisfaction. Usually, when we try to find ways to "motivate" employees we look at variables such as company policy, supervision, interpersonal relationships, working conditions, salary, status, and security. Herzberg calls these hygiene factors (KITA or kick-in-the-a-- factors) "that are extrinsic to the job . . ." and "are the primary cause of unhappiness on the job.[1]

All of us in the field of human services are being forced to look at new roles and functions as "deinstitutionalization" is being pushed through advocacy groups. We no longer have the luxury of our "ivory tower" professionalism. Our "customers" are not happy with our "product." We, on the other hand, as workers in human services areas, find it extremely threatening to change. We have been reinforced by our educational systems to be specialists, and to function in in the "medical model," which is an authoritarian rather than a democratic system. We have not often enough questioned the efficiency or efficacy of this model in new settings. Our whole system of medical delivery still focuses upon patch-up rather than prevention. Physicians, in particular, have been rewarded for choosing specialties where patients will recover. Prevention and maintenance

---

Geneva S. Folsom, "Reality Orientation – An Answer to Gerontophobia," paper presented at Conference on Successful Treatment of the Elderly Mentally Ill, Center for Aging, Duke University, May 22, 1975.

Ibid.

Ibid.

do not reinforce the M.D.'s "healer" image. Our institutions are also caught in the medical model bind. We are just now beginning to see that other models for management and maintenance of physical, psychological, socio-economic, and education problems, are perhaps more viable. Note Thomas:

> From now on, we will need, as never before, to keep the three central enterprises of medicine "to cure, to relieve, to comfort" clearly separated from each other in our minds.

An understanding of the development of our old custodial role models may be found in an article by Rosenhahn entitled "On Being Sane in Insane Places." He discusses a research study in which pseudopatients were mixed with real "patients" in twelve different psychiatric hospitals. In order to measure interaction between patients and staff, actual encounters were clocked and counted. It was shown that professional staff spent the least amount of time with patients, but even more discouraging, attendants spent only 11.3 per cent of their time with patients, and that includes the usual chores of folding laundry, etc.

Rosenhahn points out that the latent meaning of a hierarchical organization may be interpreted from these findings.

> Those with the most power have least to do with the patients, and those with the least power are most involved with them. Recall, however, that the acquisition of role-appropriate behaviors occurs mainly through observation of others, with the most powerful having the most influence. Consequently, it is understandable that attendants not only spend more time with patients than do any other members of the staff – that is required by their station in the hierarchy – but also, insofar as they learn from their superiors' behavior, spend as little time with the patients as they can. Attendants are seen mainly in the cage,* which is where the models, the action, and the power are.

The key words in this quotation are "models," "action," and "power." If staff is expected to change roles from "helpers" and "keepers" to "facilitators," they have to be in a climate where such change is valued. Instead of taking "care of" clients, they are now asked to teach self-care skills so clients will leave or, at least, be able to take care of themselves. It is much easier to tell a "helper" what to do than to give a "facilitator" room to move. In the old system the client is the last recipient of "orders." In the new system the client must set the pace for staff behavior.

Staff learn behaviors that give them rewards. In a custodial system they are rewarded for following the rules, being compliant, not thinking, keeping floors clean and clients well-behaved. Clients are rewarded for passivity, lack of initiative, following rules without asking questions, and often, for being helpless and dependent. In the deinstitutionalization process staff must be rewarded for questioning the system, advocating for the client, and for seeking ways around the old custodial "system." The client must be rewarded for initiative, independence, acquiring self-help skills, for wanting to leave the institution, and for wanting to be an adult – not someone's "baby."

D.L. Rosenhahn, "On Being Sane in Insane Places." Science, Vol. 179 (January 19, 1973). pp. 250-258.

The "cage" refers to the nursing station or office as contrasted with the ward of area where patients spend their time.

The models, the action, the power, must be seen out of the cage – and the farther out the better. The "cage" must not even be defined as the institution. Even those walls must be stretched. Everyone with whom the client comes in contact must be aware that they are an ever-present model for teaching Life Skills. If I am late, I cannot "teach" punctuality. If I am untidy, I cannot "teach" budgeting. Instead of being a keeper, I am now a model, a consultant, a teacher. My Life Skills must change to fit new concepts as the system moves forward in deinstitutionalization attempts.

Suggested Reading: F. Herzberg, "One More Time: How Do You Motivate Employees?," *Harvard Business Review* (January-February 1968), pp. 53-62.

Ralph G. Hirschowitz, M.B., Ph.D., B.Ch., "Changing Human Behavior in the State Hospital Organization," *Psychiatric Quarterly*, 43 (1969), pp. 591-611.

D.L. Rosenhahn, "On Being Sane in Insane Places," *Science*, Vol. 179 (January 19, 1973), pp. 250-258.

C. Bibliography

"Attitudes Toward the Retarded." A Summary of Studies to 1972. The President's Committee on Mental Retardation. Washington, D.C., 20201, 1972.

Blatt, B. Souls in extremis: An Anthology on Victims and Victimizers. Boston: Allyn and Bacon, 1973.

Bruiniks, A., Robert, H., Rynders, John E., and Gross, Jerry C. "Social Acceptance of Mildly Retarded Pupils in Resource Rooms in Regular Classes." American Journal of Mental Deficiency, Volume 78, Number 4 (January 1974), pp. 377-383.

Clark, G.R., Kevitz, M.S., and Rosen, M.A. Transitional Program for Institutionalized Adult Retarded. Elwyn, Pennsylvania: Elwyn Institute, 1968. (unpublished report)

Dehumanization vs Dignity. Minnesota: Department of Public Welfare, National Association of Retarded Children.

Deinstitutionalization – A Service Continuum. Developed by the Developmentally Disabled Councils of West Virginia and Virginia in cooperation with Region III, Health, Education and Welfare, Developmental Disability Council Consortium, February 1975.

Edgerton, Robert B., Ph.D., and Karno, Marvin, M.D. "Community Attitudes Toward the Hospital Care of the Mentally Retarded." Mental Retardation, Volume 10, Number 5 (October 1972).

"Environmental Variation in Community Care Facilities for Mentally Retarded Persons," American Journal of Mental Deficiency, Volume 78 (1974).

"Factors Determining Residential Placement of Mentally Retarded Children." American Journal of Mental Deficiency.

Fields, Suzanne. "I. Foster Communities for the Mentally Ill." Innovations (Fall 1974)

Granger, B.P. "Dilemmas of Re-organizing Institutions." Mental Retardation, Volume 10 (1972), pp. 3-7

———. "The Dilemma of Humanizing Warehouses: An Analysis of One Administrative Change Strategy to Improve Institutions for the Mentally Retarded." Doctoral dissertation, Brandeis University, 1971.

Hammarback, M.D. "An Investigation of the Community Adaptation Schedule with Educable Mentally Retarded Adolescents and Young Adults." Doctoral dissertation, University of Oregon, 1969. (Unpublished manuscript)

Hesel, E.D. "Residential Service." Mental Retardation, Volume 3 (1971).

"Individualized Data Base." Pomona, California: Neuropsychiatric Institute-Pacific State Hospital Research Group, August 1973.

Justice, R. Bradley, J., O'Connor, G. "Foster Family Care for the Retarded: Management Concerns of the Caretaker." Mental Retardation, Volume 9 (August 1971)

Mercer, Jane. "Patterns of Family Crisis Related to Reacceptance of the Retardate." American Journal of Mental Deficiency, Volume 71 (August 1966).

"Problems Reported by Parents of Mentally Retarded Children – Who Helps?" American Journal of Mental Deficiency, Volume 75 (1971).

Roen, S.R., and Burnes, A.H. Community Adaptation Schedule and Preliminary Manual. New York: Behavioral Publications, Inc., 1968.

Ross, P. "Evolutionary Changes of the Residential Facility." In A.A. Bumeister and E.C. Butterfield, Residential Facilities for the Mentally Retarded. Chicago: Aldene, 1970.

Santiestevan, Henry. Deinstitutionalization: Out of their beds and into the Street. American Federation of State, County and Municipal Employees, 1625 L Street, N.W., Washington, D.C. 20036, February 1975.

Scheerenberger, R. "Management Systems and Styles in a Residential Facility for the Mentally Retarded." Mental Retardation, Volume 9 (1971), pp. 22-24.

Schulman, Eveline D. Intervention in Human Services, St. Louis: The C.V. Mosby Company, 1974.

Shafter, A.J. "A Philosophy of Administration: A Revisit." Mental Retardation, Volume 9 (1971), pp. 3-5.

———. "Criteria for Selecting Institutionalized Mental Defectives for Vocational Placement." American Journal of Mental Deficiencies, Volume 61 (1957), pp. 599-616.

"A Summer-Work Study Program for High School Students," Part IV (NIH Grant #5-R01 MH1 476). Department of Psychology, University of Wyoming, January, 1973.

Warren, S.A., and Berkowitz, A.J. "Editorial: The Institutional Dilemma – Administrative Organization." Mental Retardation, Volume 9 (1971), p. 2.

Windle, C., Sabagh, G., Brown, S., and Dingman, H. "Caretaker Characteristics and Placement Success." American Journal of Mental Deficiencies, Volume 65 (May 1961).

Windle, C. "Prognosis of Mental Subnormals." American Journal of Mental Deficiencies, Monogram Supplement, Volume 66 (1962).

Windle, C., Stewart, E., and Brown, S. "Reasons for Community Failure of Released Patients." American Journal of Mental Deficiencies, Volume 65 (May, 1961).

Winds of Change. Report of a Conference on Activity Programs for Long Term Care Institutions. American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

Wolfensberger, Wolf. Normalization – The Principle of Normalization in Human Services. National Institute on Mental Retardation, 1972.

ISSUE NO. 4. WHAT'S THE ROLE OF THE COACH?
STRATEGY NO. 4. INITIATING DEINSTITUTIONALIZATION PLAYS

A. Pre-Post Test for Role of Superintendent in Deinstitutionalization

Instructions: Fill in appropriate column with check-mark (✓)

	Yes	No	Maybe
1. Superintendent (or top management) is key person in process of deinstitutionalization.			
2. Superintendent should state philosophy for institution so everyone knows its goals and objectives.			
3. In the process of deinstitutionalization the superintendent's key role is to run a good institution.			
4. As a strong leader, superintendent should tell staff what to do.			
5. Superintendent should delegate responsibilities.			
6. Superintendent should let people make decisions and back them up, even when they make a mistake.			
7. Superintendent should spend at least half his/her time relating to community.			
8. Superintendent should tell families that institution will assume full responsibility for their relative.			
9. Once client is discharged from institution, superintendent should shift all responsibility to community agencies.			
10. Autocratic superintendent may give staff more sense of security than one who utilizes democratic management techniques.			

Scoring: See Appendix A

B. Introduction

No project can assist any institution unless the goals and objectives of both are the same. The role of the superintendent (or leader) of any institutional facility must be that of model for the rest of the staff. If the leader is afraid to advocate deinstitutional principles, word will spread that system-fighters are low in the ranks of the value system. If the leader is trying to protect his/her own territory, staff will realize that territorial rights is the name of the game. If the leader is just trying to hold still so his/her superiors will not be upset, staff will follow suit. If the leader is afraid of taking chances, staff will row the boat just hard enough to keep it from sinking. If the leader plays "Captain" all the time, the crew will turn off their heads and say "Aye, Aye, Sir," and go on about their usual institutional games. If the leader is a hot-shot 90-day wonder, the old guard will patiently out-wait this ambitious climber, because "this too shall pass." If the leader feels threatened by the powers above, this fear system will filter down to the final helpless victim – the client.

The effectiveness of this system in helping facilities to be accountable for normalization is dependent upon the philosophy of the superintendent. The complexity of the role of superintendent caught in implementing change is enormous. Without a humanistic and global approach to problems of deinstitutionalization on the part of the superintendent, a Life Skills approach will be difficult, if not impossible. The superintendent must be a master coach with a keen sense of timing and balance. This is particularly essential in a situation where too often the players have not been in the same town, much less the same ball-park.

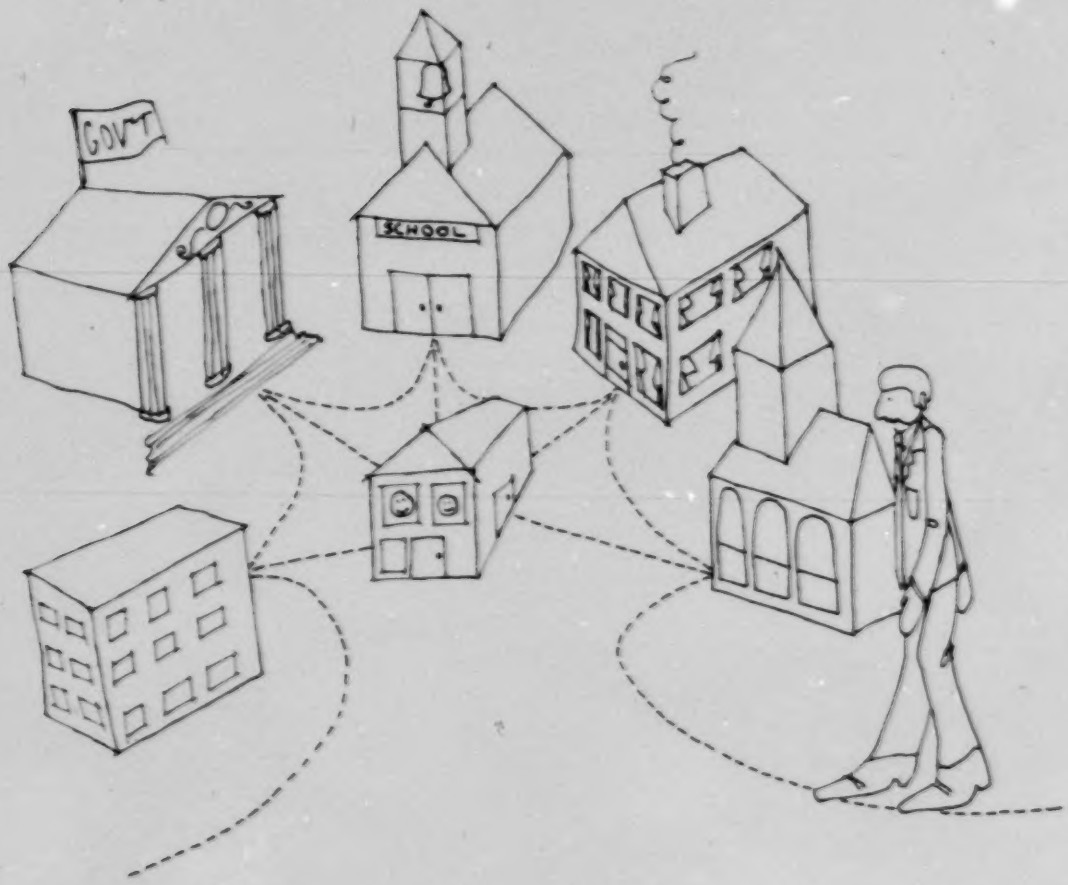
The Life Skills approach to the problem should help insure that clients are ready to adjust to the outside world. Precipitous discharge is tantamount to creating another system even less humanistic than the one we have already created. Deinstitutionalization is rapidly becoming a national disgrace. It does no good to place clients "out of their beds and into the streets"* if we have not adequately prepared them for a successful adjustment. Some clients will need the institution for permanent placement. The deinstitutionalization efforts within the institution must be directed toward creating an environment in which the individual can attain the most independence possible.

---

*Henry Santiestevan, *Deinstitutionalization: Out of Their Beds and Into the Streets* (Washington, D.C.: American Federation of State, County and Municipal Employees, 1625 L Street, N.W., 20036, February 1975), p. 43.

Slide No. 4-a. The Role of the Deinstitutionalized Superintendent

SUPERINTENDENT'S ROLE - DEINSTITUTIONALIZATION



1. Discussion:	Suggested Responses
What is the focal point of this picture?	Client and staff
Who is in the center?	Client and staff
Who has the control?	Client (needs of client).
Where is the control?	Wherever the needs can best be met.
What is the communication flow?	Out, around, back, in, out, through, up, sideways.

What does the superintendent value?	The client. Interaction with the community resources who can best serve the specific needs of the client, whether that be pushing for new legislation or working with agencies and families.
What are the community involvements?	All available resources: families, churches, schools, vocational rehabilitation, social security, physicians, dentists, Community Mental Health/Retardation Centers, law enforcement agencies, local industries, volunteers, legislators, Developmental Disabilities Council, etc.
What is the role of the client here?	Central figure in decision-making re services needed to maintain or prepare client for a less-restricted environmental setting.
What is the role of the staff?	Facilitators and active team members in habilitating the client to live in the outside world, or to structure the most growth-facilitating climate within an institution.
What is the role of the institution in the community?	To be an integral part of the continuum of services for the developmentally disabled. To supply what the community lacks. To be a focal point for screening, habilitation, out-reach, and follow-through, for those who need the services provided only within institution.
What is the effect of this type of leadership on staff?	They are humanized, become involved, are accountable, and are deinstitutionalized. They see themselves as initiators, not merely responders. They are active participants in the rehabilitation process. They feel they are supported so are more inclined in turn to support each other's efforts. There is less territorial protection; they are goal-directed rather than politically-directed, and they feel important because of their problem-solving abilities rather than their abilities to beat the system. They become active assisters instead of passive resisters.

2. **Experiential Exercise:**

   A. Problem-solving in groups. Be sure groups are interdisciplinary in nature and include administrative staff if possible. On a scale of 1-10 for each discussion question, come

to a group consensus re how your superintendent would rate compared to one depicted in slide. Compare group scores when exercise completed. (See 3. Group Process.)

B. Discussion. Do staff views of the superintendent and institution coincide? If not, what are the discrepancies? What are the similarities? How close do staff and superintendent views in deinstitutionalization coincide?

After reading Queene article (see Required Readings), discuss. Compare these ideas with those of other superintendents. What are the similarities? What are the differences? Do you agree with these concepts? Why? Why not?

3. Group Process:

Elicit and record answers to questions. No one answer is correct; however, the suggested response should either come from the group or be added by the instructor. Observe group to see if any particular facilitator roles are valued by any discipline or occupation. Try to get all members of the group tuned into these concepts and reward all responses which indicate they are thinking of new roles and functions for themselves or the group with whom they are identified. Watch for responses that indicate resistence to these concepts and deal with this when the group is comfortable enough to handle it.

Required Reading:

Roland Queene, "The Superintendent and Accountability," *Deinstitutionalization: A Service Continuum.* (Published by Developmental Disabilities Councils of West Virginia and Virginia in cooperation with Region III, HEW Developmental Disabilities Council Consortium, February 1975), pp. 97-105. (See Appendix B.)

ISSUE NO. 5. WHAT POSITION DO I PLAY?
STRATEGY NO. 5. SET UP TEAM APPROACH – ALL POSITIONS

A. Pre-Post Test

Experimental Evaluation for Use in Establishing a Baseline for Level of Effectiveness of Team Functioning (Revised 1975)

Geneva S. Folsom, Ed.D.

Instructions

This form was devised to determine your feelings and concepts about your role as part of a decision-making "team." If the group with whom you work most closely has not been officially designed as a "team," please consider it so for purposes of this evaluation. If you are working as part of a "treatment" team within a unit, this would be the basis of your evaluation. If you have an administrative role, you can respond according to your role within the administrative team (those who meet together to make decisions re client care). The ultimate use and value of this instrument will be to determine how well people work together to meet goals and objectives set for the client. Hopefully, you can respond to this instrument from the frame-work of your role within an inter-disciplinary team.

Your honest responses will help identify sources of satisfaction and dissatisfaction. After analyzing the responses, the team will be better able to reinforce the positive elements of team-building as well as to work on problems which may be hampering efficient team functioning.

The evaluation should not take more than 20 minutes to complete. Make a check mark in the column which most nearly expresses how you feel about the statements. Do not spend time thinking about it. Read the statements and respond. There are no right or wrong answers.

Scoring

Add all scores according to the weighting indicated at the top of the columns. Divide by the number of statements. If your team is functioning at a 100% level, your total score for the 40 statements will be 120. Divide this number (120) into your score to obtain the percentage at which you feel your team is functioning. For example, "a 75% level" would mean that you feel satisfied with the decision-making about 3 times out of 4.

Interpretation

If your team leader feels the team is functioning at a much higher level than other members do, you may want to look at the "Autocratic Leader" slide and concepts. If the direct-care staff rates the team at a much lower level of functioning, you may want to review their position on the autocratic team. If you think your team is functioning as a "team" and you find your perception is not in line with what team members feel, you may want to review the "Approach-to-Team" slide. If all of you are pleased with team functioning and there are no great discrepancies in responses, you are to be congratulated for your success in team-building.

Scoring: See Appendix A.

Name: _____

Position Title: _____

	Always	Most of the time	Sometimes	Never
1. We establish clear-cut goals through team effort.				
2. Our team leader lets us experiment with new skills.				
3. We work together so clients can't play us off against each other.				
4. I contribute at team meetings because I'm not afraid of consequences.				
5. Members of our team are cooperative rather than competitive.				
6. I benefit from contributions made by other team members.				
7. Our team makes decisions that benefit clients.				
8. Our team deals with important matters.				
9. Our team checks to see if decisions have been put into effect.				
10. My suggestions are incorporated into decision-making.				
11. We have been able to make changes because we stuck together as a team.				
12. We are supportive of each other on our team.				
13. Our views are accurately reflected in team decisions.				
14. Decisions should be made in a multidisciplinary group.				
15. When we come up with a solution to a problem, we implement it.				

	Always	Most of the time	Sometimes	Never
16. When we work together we see the client as a person rather than as a "problem."				
17. When I am working with the team, I can use my full potential.				
18. Team members are aware of my feelings during team meetings.				
19. I am missed when I am absent from team meetings.				
20. Our team has backing from administration.				
21. If our team makes a decision that turns out to be wrong, we are supported by the administration.				
22. We are responsive to client's needs.				
23. We are responsive to each other's needs on this team.				
24. I feel proud to be a member of this team.				
25. I feel motivated at work.				
26. We are supportive of each other outside of this group.				
27. I feel I am identified as a member of this team.				
28. Our team has a good attitude toward our clients.				
29. We stay on the subject at team meetings.				
30. Our team meetings are organized in an efficient manner.				
31. Our team is effective in defining problem areas.				
32. Our clients have a good attitude toward our team.				

	Always	Most of the time	Sometimes	Never
33. Leadership on our team passes around to team members according to the needs of the client.				
34. Our team is working with people outside the institution.				
35. Being part of a team is more motivating than working alone.				
36. Team meetings are a learning experience.				
37. Team meetings are helpful in keeping communications open.				
38. I feel we would be more effective if we met more often.				
39. We work well with all types of clients.				
40. We are working toward deinstitutionalization with our clients.				

B. Introduction

You have just completed an evaluation form which gives your "team" some idea of how well you are functioning as a unit. You should have some idea of how well you are working together, in what areas you are not functioning well as a unit, and how you see your role in relation to others with whom you are working.

There are many types of teams and styles of leadership. Some are productive in some circumstances and non-productive in others. Since we are developing strategies for deinstitutionalization, we must work under the premise that many people will be involved, both within and outside of the facility. We can therefore presume that the better we work together, the more effective we will be in solving problems for multi-handicapped clients.

There are times when a "team" decision is inappropriate. There are times when democratic leadership is ineffective. The more we understand various leadership styles and management systems the better we will be able to choose those styles and management systems which are most appropriate for immediate problem-solving. Most institutions have operated under autocratic leadership and management styles because they are institution-centered operations. With the emphasis on deinstitutionalization efforts, however, client-centered styles of management and leadership are more appropriate and productive.

Many institutions (educational, governmental, legal, etc.) are in process of change. Change creates anxiety for staff and for clients. We cannot eliminate anxiety but we can help staff and clients understand some of the reasons for, and directions of, change. As the role of the institution changes, the roles of leaders change. It is helpful to assist people in understanding their own leadership styles and in looking at alternative styles so they can apply the appropriate style to the appropriate situation*. The concepts presented in this section should help staff gain insight into their own management styles as well as into the management system in which they are working.

C. Primary Concepts

Show Slide No. 5-a "The Non-Team Approach" - Autocratic Leadership

AUTOCRATIC LEADERSHIP

APPROPRIATE

1. WHEN THERE IS AN EMERGENCY
2. IN SURGERY
3. WHEN EXPERT IS ONLY ONE WITH KNOWLEDGE AND SKILLS NEEDED TO PROBLEM SOLVE

---

* For further identification of leadership styles and roles, see Appendix C.

1. Discussion	Suggested Responses
Who is the leader here?	The person on the top.
How do you know?	He is the King.
Where is the client?	At the bottom.
How do you know?	Because all orders are passed down.
Who is happy here?	The king.
Who is unhappy here?	The Staff.
Why are they unhappy?	No decision-making or feedback, dehumanized, not valued.
What is the communication flow?	Down, one way.
When is this an appropriate style of leadership?	During emergency, surgery, and when expert is only one with knowledge and skills needed to problem-solve.
When is this an inappropriate style of leadership?	When you need many people to help problem-solve.
When do you use this style of leadership? Do you know what style of leadership you use?	When I don't trust anyone else to know what I know. When I am threatened. When I know that I am the authority on the particular subject and I need to assume an active leadership role. When I assume an authority role in a new situation and need to give security to the group until they are ready to assume their responsibility.
Where would you find this type of management system?	In a custodial institution. Where there is an emergency. Where the leader is the expert. In surgery.

2. Experiential Exercise:

A. Discuss this management style in relation to your own institution. As a leader, when do you use this style of management? How successful or non-successful is it? When does it facilitate decision-making? When does it hinder? How do you feel in this role? (See 3. Group Process.)

As a subordinate or member of a team, how do you feel when the leader uses this style of management? When are you comfortable with this? When do you resent it?

As a client, what are your feelings about yourself in this type of management system? When do you appreciate it? When do you resent it?

B. (1) Examine yourself through the use of the Styles of Influence (Appendix 3). Did you learn anything new about yourself? How do you feel about what you found out? Did this support your view of your own management style?

(2) Write a brief description of your own management style. Do not sign your name. Pass these in and redistribute. See if others can identify you by what they recognize in your behavior.

3. **Group Process:**

Elicit answers and responses. Try to obtain responses from all group members and from all areas. Give positive reinforcement for all answers. There are no right and wrong responses. Begin to pin-point areas of conflict between administrative and professional staff; between mid-management and top management; among disciplines within a particular group. Spend time on questions no. 8 and 9. Observe differences between answers from management and non-management.

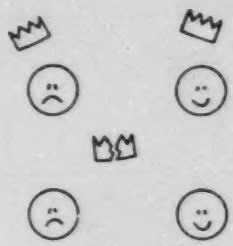
4. **Suggested reading:**

F. Herzberg, "One More Time: How do you Motivate Employees?," Harvard Business Review (January-February 1968), pp. 53-62.

Individual and Group Effectiveness Training: A Handbook for Trainees, Department of Medicine and Surgery, Veterans Administration, Washington, D.C. (June 1973).

Show Slide 5-B "You Be It" Management

"YOU BE IT" MANAGEMENT



1. WHEN YOU'RE TRYING TO GIVE UP THE AUTOCRATIC ROLE (OVERKILL)
2. WHEN YOU'RE NOT SURE HOW THE "TROOPS" WILL BEHAVE
3. WHEN YOU HAVEN'T DEFINED THE GOALS
4. WHEN YOU'RE IN A NEW SITUATION

1. **Discussion:**	**Suggested Responses:**
Who is the leader here?	No one knows: it's up for grabs.
How do you know?	Everyone looks confused.
Where is the client?	Nowhere in sight. There are no clear-cut lines of communication.
Who is happy here?	This is unclear: some are happy, some are not - ambivalence, uncertainty.
What is the communication flow?	There is none.
When is this an appropriate style of management?	When you are trying to give up the autocratic role (overkill). When you're not sure how the troops will behave. When you haven't defined the goals. When you're in a new situation; trying to let leadership emerge.

Why is this style of management confusing to staff?

They don't know where to find the leader.

The leader fluctuates from autocratic to laissez-faire depending upon his/her anxiety level.

Staff doesn't know how far they can move without fear of reprisal.

Staff can't map out action plans because leader won't stand still.

2. **Experiential Exercise:**

   A. Obtain specific examples of instances in which this type of management was used. If possible, obtain examples from leaders. When did they use this type of management, why did they choose to use it, and what responses did it elicit? (See 3. Group Process)

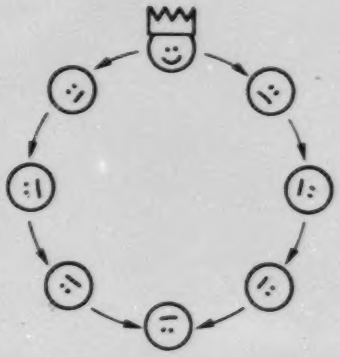
   B. Repeat for staff who are working under this type of management.

3. **Group Process:**

   Elicit and record responses. Obtain responses from all staff levels to procure feed-back from management as well as staff. Observe groups as they work through experiential exercises. Step out of the leadership position and see who assumes the role. Point this out later. Also point out any anxieties you saw develop because of your exercising this "You Be It" style of management.

Show Slide No. 5-c "Lip-Service" Team ("Approach to Team" Management)

"APPROACH-TO-TEAM" MANAGEMENT



A BENEVOLENT DICTATORSHIP:

1. **WHEN YOU HAVE MEMBERS OF A GROUP CONTRIBUTING INFORMATION AND DON'T NEED TO PROBLEM SOLVE**

2. **WHEN YOU'RE TRYING TO APPEAR TO BE DEMOCRATIC**

1. Discussion:	Suggested Responses
Who is the leader here?	The one with the crown.
How do you know?	He is smiling; he has the power.
Where is the client?	Nowhere in sight.
What is the communication flow?	Down from the leader.
When is this style of management appropriate?	When you have members of a group contributing information but you do not need to problem-solve. For example, an intake interview. You are just collecting information; the leader serves more as a data-collector than a leader.
When is this style of management inappropriate?	Most of the time. This can be an insidious type of management. The leader tries to appear democratic and asks for in-put but does not really listen. The leader makes final decisions independently. Staff is fooled by the benevolent dictator. They end up demoralized when they find their contribution was not valued.
Where is the client?	Nowhere in sight. If he is in the circle he is as unhappy as the staff. No one is listening to him/her.
Where would you find this type of management system?	In the old custodial systems, the baronial kingdom. The good kind superintendent never rocks the boat or fights the system. Dependent staff and clients are happy with this leader; they don't have to be involved. Staff who want to change the status-quo are unhappy in this climate.

2. **Experiential Exercise:**

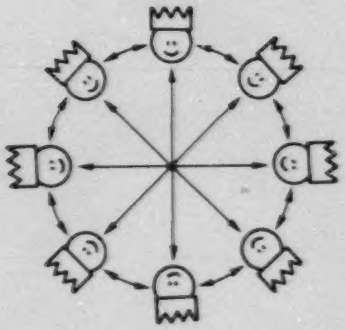
A. Within groups, individuals should illustrate situations when working under a "benevolent dictatorship." How did they feel about their role under such a leader? What happened to clients under such leadership? How was the leader accepted in the community? How did the institution interface with the community? (See 3. Group Process.)

B. Discuss your own leadership style. When have you used this role? How did it work? When was it successful? When did it fail? How does it cause confusion?

3. **Group Process:**

Particularly notice management's reaction to this discussion. If you have a "benevolent dictator" this is probably the most difficult style to identify. This type of leader can cause dissension within a staff. The "old-timers" (If there are any) are usually fairly content under this arrangement. New staff who are client advocates have difficulty. See if this kind of split occurs in your groups during this discussion.

PARTICIPATORY MANAGEMENT



1. WHEN YOU HAVE A DEMOCRATIC LEADER AND STYLE OF MANAGEMENT
2. WHEN YOU NEED EVERYONE TO HELP PROBLEM-SOLVE
3. WHEN YOU TRULY BELIEVE EVERYONE IS IMPORTANT TO THE SUCCESS OF THE PROJECT
4. WHEN YOU WANT TO FULLY UTILIZE STAFF IN HABILITATIVE PROCESS

Slide No. 5-d: Team Approach

1. Discussion	Suggested Responses
Who is the leader here?	Everyone; anyone who is contributing to the team effort.
How do you know?	They are all smiling. They are all important (crown).
Where is the client?	In the middle, part of the group, the focus of the team meeting.
What is the communication flow?	Around, across, through, to, from, (not down).
In what way is the Team Approach different from the other three managerial styles?	It involves everyone; including the client. It is client-oriented. It is oriented toward problem-solving. It is open communication. It is a feed back system. It allows everyone to be accountable. Once the team decision has been made, team members are accountable to abide by the decision. It is a supportive system.

It is a system which utilizes all staff as "therapuetic" agents.

It involves everyone in decision-making, giving them an investment in the outcome.

It gives staff a feeling of achievement and recognition for achievement – a motivating factor.

It allows for growth because it creates a learning environment.

Each individual's expertise is utilized in problem-solving.

When is this style of management appropriate?

When you have a democratic leader and style of management.

When you need everyone to help problem-solve.

When you truly believe everyone is important to the success of the project.

When you want to fully utilize staff in the habilitative process.

Who is happy here?

Everyone in this slide. Team meetings are not always "happy." In a good team there is open discussion, disagreement, anger. The main clue is *open* communication. This can be a very uncomfortable situation until staff begins to accept responsibility and becomes involved in the process of active programming. Leaders are often miserable until they learn that the group can function in a positive problem-solving manner. The "Team Approach" involves risk-taking for both management and staff.

Where is the client?

Right in the middle of the action, sharing in the decision-making, involved in the process of change, taking responsibility for his/her own program, listening and being listened to, talking and being heard, one of the team members.

Where should you find this type of management system?

In any insitution that is trying to change from a custodial model to an educational model, is trying to move into the community, is in the process of deinstitutionalization. This is particularly important as the institution begins working with outside agencies and families. They should be included as an integral part of the team. If they are included in planning, they will help insure success for the program. They will learn from each other and will be able to utilize resources in more innovative ways.

2. **Experiential Exercise:**

A. Groups pick a "problem" client. Define problem and make team decision how to handle it. Limit this meeting to 30 minutes. Have someone observe the group. Keep tab of who talks? how many times? to whom the remarks were directed? who gave suggestions? how the group arrived at the consensus? They are to put this decision into effect. Don't let them play games with the exercise.

B. Each group member should react to this "team" decision. Does (s)he feel (s)he contributed to the decision? Does (s)he feel (s)he will play a part in the execution of this treatment plan? Does (s)he feel any one individual could have come up with a equally effective solution? If so, who? Repeat previous 9 questions. Did these points hold true in this "team" meeting?

Required Reading: *Surveyor Course Manual for Intermediate Care Facility for Mental Retardation:* Developed at Tulane University, New Orleans, Louisiana, Revised January 1975. 304 pp. pp. 96-101.

D. Bibliography

Anderson, Alice V. "Orienting Parents to a Clinic for the Retarded." Children (September-October 1962), pp. 178-182.

Arnold, I., and Goodman, L. "Homemaker Services to Families with Young Retarded Children." Children (July-August 1966) pp. 149-152. (Reprint available from HEW).

Bernstein, L., and Dana, R.H. Interviewing and the Health Professions. New York: Appleton-Century-Crofts, 1970.

Bittle, Lester R. What Every Supervisor Should Know. New York: McGraw-Hill, 1968.

Borben, W., Marler, D., and Andores, L. "The Psychiatric Team: Myth and Mystique." American Journal of Psychiatry, Volume 122. Number 6 (December 1965).

Braik, A. "Public Welfare Serves the Mentally Retarded Child." Public Welfare (April 1967), pp. 110-115. (Reprint available from HEW).

Burke, R., and Hanson, P. Dimensions of Managerial Behavior. Houston Conference of Veterans Administration, 1973.

Center, Allen. Public Relations Ideas in Action. New York: McGraw-Hill, 1957.

Cleland, C.C. "Intra-institutional Administrative Problems: Employee Communications." Training School Bulletin, Volume 64 (1967), pp. 81-91.

Coch. L., and French, J.R.P., Jr. "Overcoming Resistence to Change." Human Relations (1948), pp. 512-532.

Deinstitutionalization – A Service Continuum. Developmental Disabilities Councils of West Virginia and Virginia in cooperation with Region III, HEW Developmental Disabilities Council Consortium, February 1975.

Dittman, L. The Mentally Retarded Child at Home: Manual for Parents. Children's Bureau Publication 374. (Reprint available from HEW).

Edge, L. "Deinstitutionalization – Home Life Program." Deinstitutionalization – A Service Continuum, pp. 39.43.

Folsom, Geneva S., "Experimental Evaluation Form for Use in Establishing a Baseline for Level of Treatment Team Functioning." Mental Health and Behavioral Sciences Services, VA Central Office, February 1973.

Folsom, G., and Folsom, J.C. "Team Method of Treating Senility May Contain the Seed for Medical Revolution." Nursing Care (December 1973), pp. 17-23.

Franklin, Owen E. "Serving the Mentally Retarded." Public Welfare (October 1965), pp. 281-284. (Reprint available from HEW).

Given, William, How to Manage People. Englewood Cliffs, New Jersey: Prentice-Hall, 1964.

Gordon, T. Parent Effectiveness Training, Peter H. Wyden Inc., New York., 1970.

Hayakawa, S.E. Language in Thought and Action. New York: Harcourt, 1963.

Hepner, Harry. How to Live and Work Successfully with People in Business. Englewood Cliffs, New Jersey: Prentice-Hall, 1952.

Herzberg, F. "One More Time: How Do You Motivate Employees?" Harvard Business Review (January-February 1968), pp. 53-62.

Historical Perspective on Mental Retardation During the Decade 1954-1964. A Compilation of Articles in Children. Children's Bureau, U.S. Department of Health, Education and Welfare, 1964.

Individual and Group Effectiveness Training: A Handbook for Trainers. Department of Medicine and Surgery, Beterans Administration, Washington, D.C., June 1973.

Kahne, M.C. 'Bureaucrat: Structure and Impersonal Experience in Mental Hospitals." Psychiatry: Journal of Interpersonal Process, Volume 22 (1959), pp. 363-375.

Krieger, G. "Training Nursing Assistants for a Subprofessional Role." Mental Hygiene, Volume 54 (January 1970).

Kurtz, Harold. Public Relations for Hospitals. Springfield, Illinois: Thomas; 1964.

Lassen, P. "The Client as Co-Manager in Rehabilitation." A speech presented at the 17th Spinal Cord Injury Conference of the Veterans Administration, September-October, 1969.

Levin, K. "Frontiers in Group Dynamics." Human Relations (1947), pp. 5-41.

Lippit, R., Watson, Jr., and Westley, B. The Dynamics of Planned Change. New York: Harcourt Brace, 1968.

Morgan, E.D. "Social Aspects of Rehabilitation of the Severely Disabled." A speech presented at the 17th Annual Spinal Cord Injury Conference of the Veteran Administration, September-October, 1969.

Pelau, H.E. "Must Laboring Together Be Called 'Teamwork?'" American Journal of Orthopsychiatry, Volume 30 (1960), pp. 103-108.

Rosenhan, D.L. On Being Sane in Insane Places. Science, Volume 179 (January 19, 1973), pp. 250-258.

Schulman, Eveline D. Intervention in Human Services. St. Louis: The C.V. Mosby Company, 1974.

Straight E., Schaffer, R., and Folsom, J. "Patient Self-Care: Its Impact on Psychiatric Hospital Staff." Psychiatric Quarterly, Volume 47 (1973).

Surveyor Course Manual for Intermediate Care Facility for Mental Retardation. Developed at Tulane University Department of Health Services Administration, School of Public Health and Tropical Medicine, 1430 Tulane Avenue, New Orleans, Louisiana 70112, October 1974, pp. 96-101.

Wagner, P., Sternlicht: "Retarded Persons as 'teachers': Retarded Adolescents Tutoring Retarded Children." American Journal of Mental Definiciency, Volume 79 (1975), pp. 674-679.

Winds of Change: Report of a Conference on Activity Programs in Long Term Care Institutions. Chicago, Illinois: American Hospital Association, 1971.

ISSUE NO. 6. HOW DO WE KEEP OUR SIGNALS STRAIGHT?
STRATEGY NO. 6. ESTABLISH A CONSISTENT COMMUNICATION SYSTEM

A. Pre-Post Test – Attitude Therapy

Instructions: Fill in appropriate column with a check-mark (√)

	True	I think so	I don't know	False
1. *Attitude Therapy* is a systems approach to communication.				
2. *Attitude Therapy* is a behavior modification approach based on clustering of behaviors.				
3. Through the use of *Attitude Therapy* we can change the attitudes of the clients.				
4. *Attitude Therapy* is a framework developed to promote consistency in a therapeutic milieu.				
5. The use of the *Matter-of-Fact Attitude* helps staff change from helpers into change-agents.				
6. Our clients are retarded and we should do things for them because they can't help themselves.				
7. Lack of consistency of approach in a therapeutic milieu is especially confusing for the retarded.				
8. With some clients we should be very firm and expect them to perform in a nearly "normal" way.				
9. If a client loses control, we should control him/her with force.				
10. If a client is suspicious and seems angry, we should be especially friendly toward him/her.				

Scoring: See Appendix A

57

B. Introduction

Attitude Therapy was chosen as an approach to consistency in communication because staff at Forest Haven indicated communication is a problem. The system of consistent staff approach to clients was developed at the Menninger Clinic in the 1940's, and has proven successful in institutions where the Team Approach is practiced. It has further developed and simplified for staffs at large institutions through the work of James C. Folsom, M.D. (bibliographical references).

The success of deinstitutionalization efforts depends upon changing staff concepts of their basic mission. Whereas they were formerly valued and praised for their efforts in keeping clients within a protective environment, they are now asked to teach clients those skills they will need to succeed in the outside world (Life Skills). This means staff must change from being "helpers" and "keepers" to "facilitators." The *Attitude Therapy* framework can be most helpful because it is a systems approach to responding in a common way to client behaviors. It is particularly pertinent because it provides a non-threatening device to change staff from custodial behaviors to more treatment or educationally-oriented behaviors and philosophies. Through learning these *"Attitudes,"* staff can be attuned to more appropriate ways of responding based on client needs. Emphasis should be placed upon instructing staff in the *Matter-of-Fact* (Normal) *Attitude* which allows the client to accept responsibility for change and involves the client as a "normal" person rather than as a "patient" or "developmentally disabled person." Once staff begins approaching the client as "normal," the expectancy level in both staff and clients changes markedly.

Recognizing the importance of those who most directly influence changes in behavior, this communication system has proven most effective in recognizing every member of a large staff as integral to the rehabilitation process. One of the main advantages of such a system is that it offers a framework for true Team Approach. It provides a relatively simple process for clustering behaviors, and gives staff patterns of communication which are designed to provide consistency in the client's environment. *Attitude Therapy* structures communication so there is adequate imput and feedback within an institutional setting. Such as system is more effective in a 24-hour facility. However, families or day care personnel can be taught the technique so that consistency of approach is possible despite partial-care status. It provides a framework for follow-through with other agencies as clients are in process of deinstitutionalization. Without such a framework the client can become entagled in situations where reinforcement systems are inconsistent. The client can, therefore, never learn appropriate behavior. If one person ignores tardiness on the job and the ward-level person punishes late clients, the clients do not know whether or not punctuality is important on the job.

In spite of the fact that clients may be "developmentally disabled," they quickly learn how to play staff off against each other. Clients learn which staff member to run to for sympathy if another staff member makes demands upon them. The second staff member "babies" or "mothers" them and lets them know the first staff member was mean and unreasonable. The only thing clients can learn in this situation is how to be better manipulators. They also learn that staff members do not respect each other. This is hardly the ideal climate in which they can learn to be responsible in a work or living situation.

Clients learn by modeling behaviors of staff members. Inconsistent modeling leads to inconsistent learning. Consistency in the learning environment is particularly essential for the developmentally disabled. It is just as important in learning correct behaviors as it is in learning how to dress, toilet, or self-feed.

Attitude Therapy is a behavior modification approach. It gives guidelines to staff so their behaviors will change client behavior in a desired direction. It provides controls for clients as they become able to assume controls themselves. It builds consistent controls based on client needs. It structures staff so their needs are met, but not at the expense of clients.

Attitudes may be viewed on a continuum where the controls from staff are broader as behavior deviates from the norm. As client behavior changes toward the norm, the staff changes their behavior toward that prescribed Attitude *(Matter-of-Fact)* which is geared toward giving the controls to the client to manage his/her own behavior. *Attitudes* assumed by staff should be viewed as guidelines on a continuum rather than as rigid lines of demarcation. Inconsistencies arise when staff fluctuate from one extreme to another, leaving the client without consistent feedback. In using *Attitude Therapy,* all members of the entire staff react to client behavior in relatively the same way. The client will then change as (s)he perceives his/her behavior is causing desirable or undesirable staff feedback.

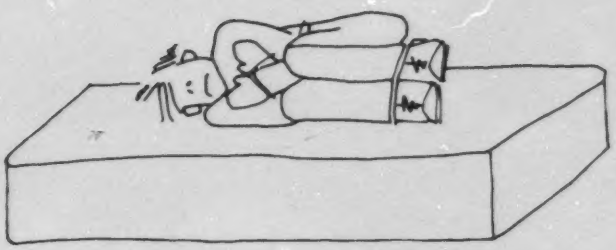
The diagram below may help illustrate the total continuum of client behavior and *Attitudes* designed to direct change in a more desirable direction.

CLIENT IS:	withdrawn	suspicious	"normal"	manipulator	depressed	upset
CLIENT NEEDS:	lots of "love"	to be let alone	"normal" response	to be faced with consequences	firm control	security
STAFF USES ATTITUDE OF:	A-F	P-F	M-O-F	firm M-O-F	K-F	No-D

C. Primary Concepts

Show Slide No. 6-a. Attitude Therapy – Active Friendliness

IF CLIENT LOOKS LIKE THIS:



YOU ACT LIKE THIS:

ACTIVE FRIENDLINESS

1. **Discussion:**

	Suggested Responses
Look at the client. Describe client's behavior. Do not interpret behavior. Describe only what you see.	Lying down, arms folded, eyes closed, hair messed up, legs in fetal position.
Look at the client. Describe what you think the client is feeling.	Withdrawn, shy, frightened, scared, "unmotivated," lonely, apathetic, unkempt, insecure, "institutionalized," no initiative, "dehumanized."
Do you ever feel like this? When?	

Do you have any clients who show this behavior? Describe someone you know who exhibits these behaviors most of the time.	
If you have a client who behaves in this manner, what would you like him/her to do? How would you want him/her to change? How would you like him/her to feel?	I would like him/her to be active, to be up doing things, to be proud of him/herself and comb his/her hair, to be out of bed and involved in life. I would like him/her to feel happy, to feel like being with friends, to feel (s)he is worthwhile.
If you let this type of person alone, what will happen?	(S)he will stay the same. (S)he doesn't have enough steam to go on his/her own. (S)he will remain shy, frightened, scared.
Look at the staff member. Describe his behavior. What is the staff member doing?	Taking something to the client – reaching out and giving attention, smiling, walking toward client.
What behaviors of yours might help this person to move?	I will need to give this person lots of attention. (S)he needs some help to get moving. (S)he needs lots of "love." I need to do *lots* of things for this person.
If you make demands on this type of person, what happens?	(S)he withdraws even more.
After we have all heaped on love and attention and this person starts moving on his/her own, what should we do?	Start rewarding him/her for his/her own initiative. Let him/her know that is what you wanted. If you keep on with the heaps of love *(Active Friendliness)* you might promote dependency. (See Bibliography.)
What if this person does not respond to our *Active Friendliness*? What if it makes him/her withdraw even more?	Call another team meeting. Consult professional; it might be depression. If so, look at *Attitude-Kind Firmness.* (See Bibliography)
Who has the control here?	You do, completely. You are taking over for this person until (s)he obtains steam to move on his/her own.

2. **Experiential Exercise:**

   A. Group should identify a client who seems to fit behavioral description. Discuss the client and come to a group decision re the prescription of *Active Friendliness,* if this

is appropriate. Discuss how each group (team) member can use *Active Friendliness* to help draw this person out. What reinforcements will you use? What can you do for this person by giving him/her something – either materially or emotionally?

B. Role-play *Active Friendliness*. One person assumes role of client. Others in the group role-play their responses. Give feed-back to each other.

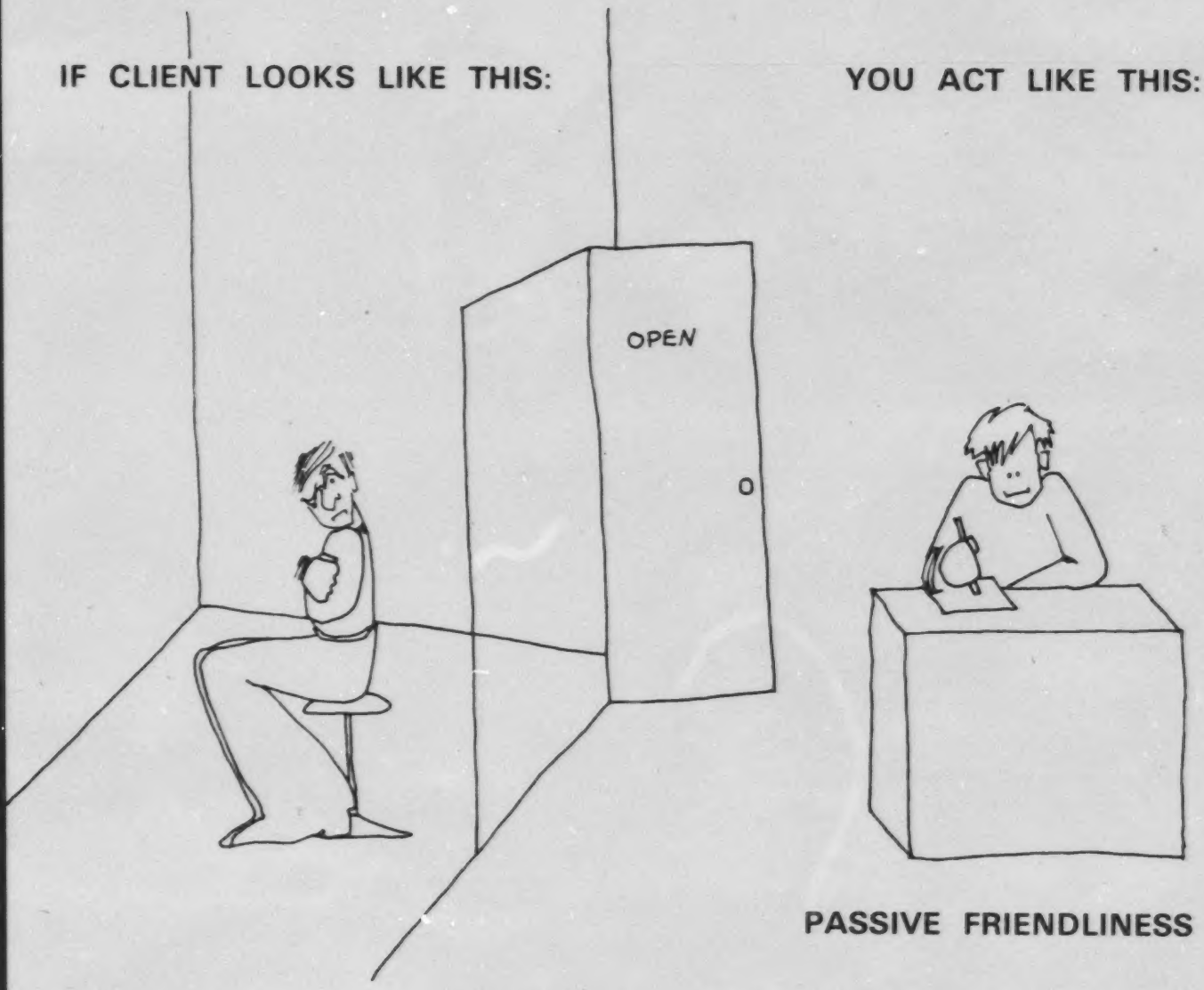
3. Group Process:

A. While the team is coming to a consensus re the assigning of the *Attitude* to the client, observe the group. Who is talking? Who is listening? Who is peace-making? Who is summarizing? How was the decision reached? Was everyone involved? How were disagreements settled? What are the non-verbal communications?

B. Observe role-playing. Keep record of responses. Did you feel the person was being Actively Friendly? Use this check list to evaluate staff response:

(1) Staff member anticipated needs of client.
(2) Staff member reached out, went to the client.
(3) Staff member took over anu did something for the client.
(4) Staff member took the initiative, did not wait to be asked.
(5) Staff member did something that indicated a caring attitude.
(6) Staff member dispensed TLC (tender loving care).

Show Slide No. 6-b. Attitude Therapy – Passive Friendliness



1. **Discussion:**

   Look at the client. Describe the client's behavior. Do not interpret behavior. Describe only what you see.

Suggested Responses

Sitting with back to staff. Arms crossed. Frowning. Body turned away from door, looking over shoulder. Sitting stiffly.

Look at client. Describe what you *think* the client is feeling.	He's angry, suspicious, defensive, doesn't want to be intruded upon, wants to be left alone, doesn't want to be crowded, has staked out his territory and doesn't want you in it.
Do you ever feel like this? When?	
Do you have any clients who show these behaviors? Describe someone you know who exhibits these behaviors most of the time.	
If you have a client who behaves in this manner, what would you like him/her to do? How would you want him/her to change? How would you like him/her to feel?	I would like him/her to be more trusting, to allow people into his/her world, to feel more comfortable with other people, to come out of his/her territory and engage in activities, to feel less suspicious of the world, to view the world as a better place.
If you crowd this person or make demands, what happens?	He will withdraw even more. He may strike out if you haven't read his signals well enough to leave him alone.
Look at staff member. Describe behavior.	Going about his business. There, but not moving toward client. Door is open, but he's staying in his territory. Door says "Open" to indicate he is available when needed.
What behaviors of yours might make this person feel more comfortable, and less uptight?	Passive behavior; don't crowd him. Give him space. Let him get himself together. Tell him what's available but let him make the choice of whether or not to take it. Be courteous but keep your distance.
What should we do if this person becomes more friendly and starts reaching out more?	Move to *Matter-of-Fact.* Read his signals – if he is friendly, be friendly. If he shifts gears toward being more "normal," you shift gears toward that approach, but let him set the pace.
What if this person does not become less suspicious, or does not reach out more and remains isolated?	Review in team meeting. Maybe you misread the signals. You may have an *Active Friendly* syndrome. The withdrawal may be more than you previously estimated. Cautiously try the *Active Friendly* approach and observe response.
Who has the control here?	Both of you; the client is telling you how (s)he feels. You are responding correctly. The client changes in the way you want.

2. **Experiential Exercise:**

A. Group should identify a client who seems to fit this behavioral description. Discuss the client and make group decision re the prescription of *Passive Friendliness*, if this is appropriate. Discuss how each team member can use *Passive Friendliness* in his/her approach to this client. Where have you been making demands? How can you stop making these demands? What really forces this person back into his/her psychological corner? (See 3-A.)

B. Role-play *Passive Friendliness*. One person assumes role of client who needs this approach. Others in group role-play their responses. (See 3-B.)

3. **Group Process:**

A. While Team is coming to a consenses re assigning of *Attitude* to client, observe group. Who talks most? Who talks least? Are there any shifts in leadership? Are silent people let alone? Who gets the group moving? Who has the most influence? How do they exert this influence? Is the group atmosphere uptight, friendly, hostile? Does the group drift? Does one person make the final decision without using feed-back? (See B).

B. Observe role-playing. Keep record of responses. Did you feel the person was being *Passively Friendly*? Use this check list to evaluate staff response:

(1) Staff member let client alone.
(2) Staff member did not crowd client.
(3) Staff member waited for client to reach out before response (this can be verbal or non-verbal reaching out).
(4) Staff member let it be known (s)he was available. (verbally or non-verbally).
(5) Staff member did not put client on defensive.
(6) Staff member was courteous but kept distance.

Show Slide No. 6-c. Attitude Therapy – Matter-of-Fact

IF CLIENT LOOKS LIKE THIS: **YOU ACT LIKE THIS:**

MATTER-OF-FACT (NORMAL)

1.	**Discussion:**	**Suggested Responses**
	Look at the client. Describe client behavior. Do not interpret behavior. Describe only what you see.	Standing at the bus stop. Carrying a brief case. Well dressed. On time for bus. Good posture. Smiling.
	Describe what you *think* the client is feeling.	Good. Important. Independent. Part of working world. "Normal." Self-sufficient. Successful.
	Do you ever feel like this? When?	
	Do you have any clients who exhibit these behaviors?	

Describe a client who exhibits these behaviors most of the time. How close could any client come to being described in these terms? What else would you have to do with this client to get him/her out of this behavior?

Look at client in all of the basic Life Skills areas: leisure time, basic independent functioning, behavior, socialization skills, etc. In what areas is (s)he not "normal?"

If you are trying to get the client to approach "normalcy," how should you respond to or approach the client? (Look at slide).

Approach the client with an air of expectancy; "I believe you can perform these tasks just as I do."

Set realistic goals and expect performance. Think of this client as a *person*, not as a label.

Spell out consequences of undesirable behavior and stick to it. Set limits so everyone understands the rules. Deal with facts.

Be consistent. Expect the same type of response you would expect of any person outside the institution, but be sure you know what "normal" is for a person of that mental age, physical disability, etc.

Who has the control here?

No one. Each individual is his/her own control. Until the client progresses to his/her own control, (s)he will need to be in a protective environment. Controls can be on a continuum. Pass it on to him/her as soon as possible.

What if this person begins to withdraw, becomes suspicious, or begins acting out?

Return to the previously prescribed *Attitude*. You may have over-estimated the person's ability to approach "normal." (S)he may need a "booster shot" of the previous *Attitude*.

2. **Experiential Exercise:**

A. Group should identify a client (or group of clients) who seems to fit this behavioral description. All clients who are in Level I (highest functioning level) should be on this *Attitude*. They are going to be treated *Matter-of-Factly* when they get into the community; they should be treated *Matter-of-Factly* in the institution so you can see how they function in an environment which makes demands on them. (See 3-A.)

B. Role-play *Matter-of-Fact*. In your individual roles as counselors, teachers, recreation specialists, etc., make the same reasonable demands you would make on your own peer group in your day-to-day relationships with the client. Give feedback to each other. (See 3-B.)

3. Group Process:

A. While the Team is coming to a consensus re assignment of attitude to client(s), observe the group. Who supports other's suggestions? Does someone make a suggestion which is ignored by the group? Is there a searching for alternatives re decisions? Who keeps the group on target? Who summarizes? Do some people seem to be "inside" the group while others are on the fringe?

B. Observe role-playing. Keep record of responses. Did you feel those playing staff roles were *Matter-of-Fact*? Use this check-list to evaluate staff response.

(1) Staff member was honest.
(2) Staff member did not beat around the bush.
(3) Staff member indicated (s)he expected a "normal" response.
(4) Staff member didn't pull any punches.
(5) Staff member and client were in a give-and-take relationship.

Show Slide No. 6-d. Attitude Therapy — Firm Matter-of-Fact

IF CLIENT LOOKS LIKE THIS:

YOU ACT LIKE THIS:

FIRM MATTER-OF-FACT

1. **Discussion:**

   Look at the client. Describe client's behavior. Do not interpret behavior. Describe only what you see.

   Suggested Responses

   Slouching in chair. Letting cigarette drop ashes on floor. Spilling drink. Listening to radio in middle of day.

   Look at client. Describe what you *think* client is feeling.

   He's enjoying himself; he beat the system. He's being "cool." He's feeling good because he is goofing off. He is happy with his irresponsible ways.

   Do you have any clients who exhibit this kind of behavior (generally)? Describe someone who exhibits these behaviors most of the time.

If you had a client like this, what would you like him/her to do? How would you like him/her to change? How would you like him/her to feel?	I would like this type of client to learn to accept the consequences of his/her behavior. For example, if he is cutting work, he doesn't get paid. If he drops ashes, he cleans them up, etc. I would like him/her to learn to be responsible for his/her own behavior. I would like him/her to find something constructive that would give him/her a feeling of pride, not at beating the system, but in working within it.
If we do not intervene and try to change this person's behavior, what will happen?	(S)he will continue to get his/her rewards from inappropriate behavior. What may be "cool" in an institution is not going to be "cool" on the outside.
Look at the staff member. Describe his behavior.	He is looking stern. He is making demands on the client. He is expecting the client to do what he is told. He is setting limits.
What staff behaviors might help this person eliminate his/her unacceptable behavior?	Set strict limits. Be sure client knows consequences of his/her behavior. Keep all lines of communication open so client cannot manipulate staff. Do not reinforce client's "cute" behavior. Do not reward client for "getting by" with something. Do not let client con you. Do not let client excuse his/her lack of ability on "bad luck," etc. Point out ways in which client sets him/herself up to be rejected or beaten by his/her own game. Do not let client "pass the buck." Be firm, unemotional, strict, and consistent.
When person begins to change, what do we do?	Go toward a more *Matter-of-Fact Attitude*. Reinforce person for controlling his/her own behavior.
Who controls this *Attitude*?	You do. You assume control until client shows (s)he can assume it. You set the guidelines and see they are adhered to. The entire system has to be involved with clients on this *Attitude*. Establish an environment in which con-artistry does not pay off.

2. **Experiential Exercise:**

A. Group should identify a client who seems to fit this behavioral description. Discuss client and make group decisions re prescription of *Firm Matter-of-Fact.* Discuss how each team member can use *Firm Matter-of-Fact* to tighten controls for this client until (s)he learns acceptable behavior. What reinforcements exist within the system to sustain acting-out behaviors? What reinforcements can be built in to break up manipulative behaviors? (See 3-A.)

B. Role-play *Firm Matter-of-Fact.* One person assumes role of client. Others in group role-play appropriate responses. Watch for inappropriate attention-getting behaviors. Clients often play these games with somatic complaints. If they obtain attention for being "sick," this becomes a manipulative tool to escape responsibility. Con-artistry comes in all shapes and sizes. Give feed-back to each other. (See 3-B.)

3. **Group Process:**

A. While the team is coming to a consensus re assigning of *Attitude* to client, observe group. Who is supporting the client and saying (s)he does not belong in this category? Who is inclined to over-use this category? Who finds it difficult to be firm, strict, set limits? Is any particular conflict arising between disciplines? These are clients who can cause staff dissension. You may be able to work this through with the group. Make observations regarding staff members' part in maintaining some of the unacceptable behaviors.

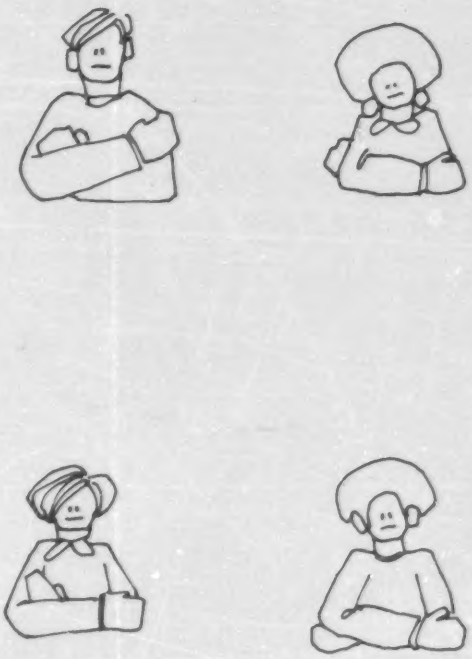
B. Observe role-playing. Keep record of responses. Did you feel the person was being *Firm Matter-of-Fact*? Use this check-list to evaluate staff response:

(1) Staff member made no allowances for inappropriate behavior.
(2) Staff member was firm.
(3) Staff member set limits so there was no doubt about expectations.
(4) Staff member checked with other staff if there was any doubt about client's tale.
(5) Staff member put responsibility on client – did not accept excuses.
(6) Staff member set realistic goals and spelled out consequences.
(7) Staff member dealt with facts, not feelings.

Show Slide No. 6-e. Attitude Therapy – No Demand

IF CLIENT LOOKS LIKE THIS:

YOU ACT LIKE THIS:



NO-DEMAND

1. **Discussion:**

	Suggested Responses
Look at client. Describe client's behavior. Do not interpret behavior.	Client is striking out. Client is wearing boxing gloves. Window is broken. Client is frowning.
Look at client. Describe what you think client is feeling.	Angry, hostile, aggressive, out-of-control, frightened, threatened, trapped.
Have you ever felt this way? When? What happened? How did you retain control?	

Describe an occasion when a client behaved in this manner. Describe staff response. How did this effect the client?	
If you move in on this person when (s)he is out of control, what happens?	(S)he usually reacts to counter-hostility and you are in a power struggle. (S)he has an advantage; (s)he has more adrenalin.
What is staff doing in the slide?	Standing still. Trying to appear small and not too obvious. Not moving toward the person. Standing in a circle. Diluting the anger by passing it from one staff member to the next. Letting the client know they are there for security but not moving in.
What if this doesn't work?	If the person is going to hurt someone else, or him/herself, or is going to run out and endanger him/herself, you might have to use physical restraint. You have to experiment with *No Demand*. If a client has learned that losing control will get staff attention, (s)he has shaped the staff to react with force. You need a well-trained staff to make this work. It takes time to break up old staff and client reactions. Let a trained person look at contingencies on this behavior.
When would you use this *Attitude*?	Only for emergencies. Any person can react in this way if pushed too far. Try to read the signals before the situation gets out of control.

2. **Experiential Exercise:**

   A. Group should identify a situation in which a client lost control. Try to reconstruct the incident. What was happening *before* the person lost control? What happened *after* the person lost control? How many times does this happen with this person? What is maintaining the behavior?

   B. Group should discuss this emergency attitude *(No Demand)*. Give positive and negative feelings about its possible effectiveness. Role-play the *No Demand* team work. How would you pass the anger around? How could you get the client to focus on different people to dilute the anger? How can you let the client know your show of strength is a security measure and not a threat? (See 3.)

3. **Group Process:**

   Observe role-playing. Keep record of responses. Was anyone making demands of any sort (verbal or non-verbal)? Use this check-list to evaluate staff response:

(1) Staff members did not move in toward client (verbally or non-verbally).
(2) Staff members did not appear threatened or frightened.
(3) Staff members did not show any anger or hostility.
(4) Staff members were supportive of each other.
(5) Staff members were quiet and calm.
(6) Staff members seemed secure and in control of the situation.

D. Bibliography

ASCD Yearbook: Learning and Mental Health in the School. Washington, D.C.: Association for Supervision and Curriculum Development. NEA, 1201 16th Street, 1966.

"Attitude Therapy and the Team Approach." Tuscaloosa, Alabama: VA Hospital, Treatment Team, November 1965, pp. 31-44.

Clarke, David L. "A New Approach to Classroom Guidance." The Education Digest (April 1958), pp. 34-36.

Folsom, Geneva. "The Uses of Attitude Therapy in the Classroom for Retarded: A Therapeutic and Consistent Approach to Discipline." Unpublished paper.

Folsom, Geneva and Students. "Teaching Materials on Attitude Therapy." Mental Health Technology Program. Bryce Hospital. Tuscaloosa, Alabama, 1973.

Folsom, James. "Attitude Therapy." A speech given by Dr. James C. Folsom, Hospital Director, V.A.H., Tuscaloosa, Alabama, at the 11th annual conference, VA Cooperative Studies in Psychiatry. New Orleans, Louisiana, March 17, 1966.

---. "Attitude Therapy Has Marked Effect." U.S. Medicine, Volume 2 (July 1966).

---. "Attitude Therapy." Speech presented at a workshop on Attitude Therapy conducted by Social Work Service, VA Hospital. Tuscaloosa, Alabama, December 10, 1964.

---. "Attitude Therapy and the Team Approach." Mental Hospitals (November 1965), pp. 307-320.

Greenwood, Edward, M.D., and Menninger, Roy, M.D. "Schools and Mental Health." Topeka, Kansas: The Menninger Foundation, October 1964.

Guide for Attitude Therapy. Tuscaloosa, Alabama: VAH, February 1972.

Guide to the Order Sheet. Topeka, Kansas: The Menninger Foundation, October 1946.

Hayden, L., Hannah, H., Cozart, N. "Attitudes in Action." The American Journal of Nursing, Volume 66 (December 1966).

Heber, Rick. "Research and Personality Disorders and Characteristics of Mentally Retarded." Mental Retardation, Volume I (1964), pp. 304-325.

"Nonprofessionals: Key Workers in Attitude Therapy." Roche Report Fortiers of Hospital Psychiatry. Volume 5 (May 15, 1968).

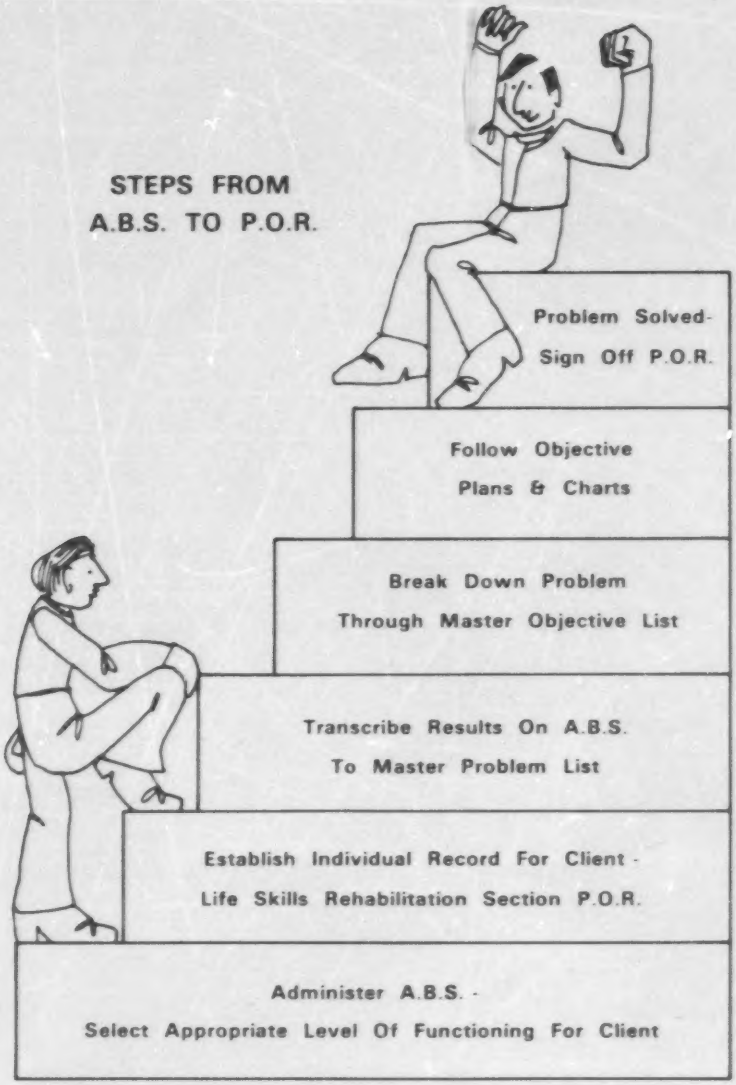
Peter, Lawrence. Prescriptive Teaching. New York: McGraw-Hill, 1965.

Phillips, E. Lankin, Wiener, Daniel, Haring, Norris. Discipline Achievement and Mental Health. Englewood Cliffs, New Jersey: Prentice-Hall, 1960.

Taulbee, Lucille. "Your Attitude Can Make a Difference." The Alabama Nurse. (December, 1968), pp.

ISSUE NO. 7. WHAT KIND OF EQUIPMENT DO I NEED FOR THIS GAME?
STRATEGY NO. 7. USE THE LIFE SKILLS REHABILITATION SECTION IN THE PROBLEM-ORIENTED-RECORD (P.O.R.)

1. Discussion:	Suggested Responses
How do we get from the A.B.S. to a systematic method of training and record-keeping?	Show Slide #7-a. Read steps starting from base (1 through 6).



How does this achieve accountability?	Once the client has attained goal, person most responsible for helping in that area signs off on record. Then we know specific problem, who and when (s)he worked with it, and when problem solved.

What if the person "signs off," but client has not actually reached goal?	Mini-Team helps serve as check-and-balance system. I may think the client can count money; I have him/her make change for me. I may discover that client is still walking out of canteen without counting change. It creates supportive system; there is no reason for anyone to sign off until objective met.
If we have not already instituted this Problem-Oriented-System, how can we use the Life Skills portion of it?	The Life Skills Rehabilitation Section can be plugged right into the Problem-Oriented-Record (P.O.R.). It can also be used as a way of introducing the P.O.R. into a facility.
What are the advantages of using this Life Skills Rehabilitation Section rather than relying on the standard P.O.R. procedures?	It is a less complex system. It is easier for direct-care staff to follow because of consistent numbering. Staff and clients are confronted with their successes as well as deficiencies, whereas the P.O.R. is a *Problem*-Oriented-Record, and therefore negative. Life Skills Rehabilitation Section has a positive orientation. It is a system which forces team-work. Although certain staff is assigned primary responsibility for specified skill-attainment, other staff must reinforce their efforts. It's a back-scratching rather than back-biting system. With this format, all staff are aware of each other's efforts. When P.O.R. is signed off and plans are made according to disciplines, it is more difficult to share information. With this format, total rehabilitation effort is emphasized rather than a fragmented departmental approach. Client is more able to see total picture rather than isolated areas of competence or incompetence. It circumvents usual professional jargon so that everyone is communicating clearly. It concentrates staff effort on functional intactness.* It gets staff into methods of remediation specifically needed by individual. It makes staff focus on therapeutic diagnosis rather than diagnostic labels.

*William B. Svoboda, M.D., "Training the Entire Individual," *Deinstitutionalization: A Service Continuum* (Published by Developmental Disabilities Councils of West Virginia and Virginia, in cooperation with Region III, HEW Developmental Disabilities Council Consortium, February 1975), pp. 35-38.

The Life Skills Rehabilitation Section provides a structured focus Mini-Team meetings, thereby saving time in pinpointing problems, setting objectives, and devising individual programs. We have one plan for meeting an objective, not twenty different plans. It gives a focus to team meetings, thereby eliminating wasted time.

It keeps a team meeting client-centered rather than discipline-centered.

1. **Discussion:**

Suggested Responses

What do I do first?

Show Slide #7-b.

STEP 1. REFER TO ABS RESULTS. SELECT APPROPRIATE LEVEL FOR CLIENT.

EXAMPLE:

LEVEL I = HIGHEST FUNCTIONING LEVEL, (TESTS ABOVE 70th PERCENTILE ON PART ONE ABS, TESTS BELOW 50th PERCENTILE PART TWO)

Step 1. Select Appropriate Level for Client. Refer to results shown on the A.B.S. Since we are concentrating on clients most likely to be deinstitutionalized first, we look for those who rated highest in functioning levels (A.B.S.).

Do we have to go by this arbitrary level system?

No. In viewing our total population, we decided this would be a good cut-off point for Level I. If you are going to adapt total system, you may want to have a committee decide levels according to your particular facility. If you are working with only a few clients, you do not need to assign levels at all.

What are advantages of a level system?

It places clients with approximately the same functioning skills together. It is easier in a large institution, with short staffing patterns, to work in groups. This provides boundaries for grouping.

It establishes staff guidelines so they know major goals for everyone with whom they work, and are more able to individualize attention. If too many levels are combined, those at lowest level may require disproportionately more time.

Are there any disadvantages to a level system?	Yes. Those who do not function at higher levels are deprived of role models. If staff is dehumanized, any level system can become a punishment rather than a reward system. Staff assigned to work with only most severely disabled can become discouraged because they see little improvement. They need some immediate gratification to balance this. Any level (or unit) system breaks down whole into manageable parts. Staff working within levels may lose sight of overall goals and objectives of deinstitutionalization. With lower levels, this may just mean working toward the most independent functioning within an institution. For the upper levels it should mean working toward placement outside institution or most independent living arrangement possible.

2. **Experiential Exercise:**

Divide your class into Mini-Team groupings. Select people who are working with the same clients. By the time you have completed this section, you will have initiated the Life Skills Rehabilitation Section of the P.O.R. for these three clients.
Evaluate the results of the test on these three clients within each Mini-Team. Place the clients in the appropriate level. Choose clients who meet criteria for Level I placement.

3. **Group Process:**

You will be working together as a Team throughout this Section. You may want to use the Team Instrument to get a baseline for how you functioned at this meeting. For a short-hand evaluation, critique your Team according to the following criteria:

a. Everyone helped problem-solve.
b. Disagreements were resolved.
c. Meeting was problem-centered.
d. Meeting was task-oriented.
e. Team resources were maximized.
f. Other resources (consulting staff) will be utilized.

Reference:

Dennis Bogen and David Aanes, "The A.B.S. as a Tool in Comprehensive M.R. programming," *Mental Retardation* (February 1975), p. 38.

Note:

We dropped Medical from P.O.M.R. since the Life Skills Rehabilitation Section is only one part of total P.O.M.R. This is a Problem-Oriented-Record, but only addresses itself to broad Life Skills areas.

1. **Discussion:**

What would be a typical item from the A.B.S. for Level I?	**Suggested Responses** Show slide #7-c.

SAMPLE ABS ITEM FOR LEVEL I
PART ONE

I. INDEPENDENT FUNCTIONING

A. EATING

(2) Eating in Public (circle only ONE)

Orders complete meal in restaurants	**3**
Orders simple meals like hamburgers or hot dogs	**2**
Orders soft drinks at soda fountain or canteen	**1**
Does not order at public eating places	**0**

Should we expect our client to have this skill?	Because we will be working with institutionalized clients as well as clients who have not necessarily been in an institution, items like this one may be marked H.N.O. (Has No Opportunity). The client will be exposed to the opportunity through the Objective Plan, so (s)he can learn skills necessary to eat in public independently.
Why are the items under #2 numbered from 3 down to 0?	Many items in the A.B.S. are written in developmental sequence. We translated these into specific objectives on the Life Skills Rehabilitation Format. Therefore, lowest level of functioning in this problem #2 from the Master Problem List is "orders soft drinks at soda fountain or canteen." Highest level of functioning indicates client is able to order a complete meal in restaurant.
Why is *Eating in Public* numbered 2 instead of 1?	This is just a sample item: It is #2 on ABS. All coding is identical to coding on the ABS. (Have trainers look at ABS. Be sure they understand coding system.)

2. **Experiential Exercise:**

Distribute copies of the A.B.S. Have group look at items and select those skills the client should have if (s)he is to move to the community. Do not go through complete A.B.S. Do enough so that group has an idea of what would constitute a Leval One Item (or skill).

After the group has worked through the concept of clustering skills in Levels, study the Master Problem List, Volume III.

1. Discussion:	Suggested Responses
After we have looked at results of the A.B.S. and have placed the client in the appropriate level, what do we do next?	Show slide #7-d. Step 2: "Members of Mini-Team Fill in Demographic Information on bottom of Life Skill Problem List."

STEP 2. MEMBERS OF MINI-TEAM FILL IN DEMOGRAPHIC INFORMATION ON BOTTOM OF LIFE SKILLS PROBLEM LIST.

EXAMPLE:

Name: John Brown

Age: 36

Sex: M

Management Device: Matter-of-Fact

Convulsive Disorders: Seizures - rare

Sensory Defects: Near-sighted - needs glasses
hard-of-hearing

Precautions: Withdraws when criticized

Medication: Dilantin T.I.D. 1½ grs. (100 mg)

Why did you include this demographic information? Isn't it included in another part of the P.O.R.?	We tried to include sufficient essential information so Rehabilitation Section would be self-contained. One problem with record-keeping systems in the past has been inaccessibility of information. Total P.O.R. will be more comprehensive; with this amount of minimal information, any direct-care staff member, volunteer, parent, or staff in another agency, can pick up this portion, plug into rehabilitation plan, and proceed with goals and objectives of deinstitutionalization efforts in Life Skills area.
What does "Management Device" mean?	This is our short-hand method of Communication-*Attitude Therapy*. Staff members, follow-through agencies and/or individuals, volunteers, etc., should have enough basic training to understand concepts.
What does "Precautions" include?	These can be precautions in any area: medical, behavior, emotional, social, education (can't read), previous failure syndrome (vocational). Example given here: "Withdraws when criticized." For volunteer, or someone who does not regularly work with client, this might provide sufficient information to preclude alienation of client before helpful intervention can be made.

Why is it necessary for a volunteer to be aware of possible seizures or medication?	So they will be prepared in the event of a seizure: Anyone working with clients should be aware of the side effects of common medications – especially the psychotropic drugs.

2. **Experiential Exercise:**

Work in Mini-Teams. Continue with the same three clients. Fill in demographic information on bottom of Master Problem List. You may need consulting help to fill in all of the information. Come to a Team decision re the *Management Device* and *Precautions*.

3. **Group Process:**

Critique your Team according to the following criteria:

a. Everyone helped problem-solve.
b. Disagreements were resolved.
c. Meeting was problem-centered.
d. Meeting was task-oriented.
e. Team resources were maximized.
f. Other resources (consulting staff) will be utilized.
g. Obtain individual feed-back on perceived roles in meetings. (Own role and roles of other Team members.)

1. **Discussion:**	**Suggested Responses**
After we have filled out the demographic information, what do we do next?	Show slide #7-e. Step 3. "Transcribe Results from A.B.S. to Life Skills Master Problem List. If item was passed, indicate on Date Resolved column."

STEP 3. TRANSCRIBE RESULTS FROM ABS ONTO LIFE SKILLS MASTER PROBLEM LIST. IF PROBLEM WAS RESOLVED, INDICATE ON "DATE RESOLVED" COLUMN.

EXAMPLE:

DATE	INITIAL	PROB NO.	LIFE SKILLS MASTER PROBLEM LIST - - LEVEL I (selected from ABS - - part one)	DATE RESOLVED	INITIAL
3/28/75	RBC	2	Eating in Public		
3/28/75	RBC	4	Table manners	3/28/75	RBC
3/28/75	RBC	18	Public Transportation		

Is this the format for the standard Problem-Oriented-Record? (Explain categories.)

Yes, with two exceptions. Look at categories from Left to Right.

Date. Indicates date problem defined.

Initial. Indicates who identified problem. (If it is medical problem, M.D. signs; if it is a nursing care problem, R.N. signs, etc.)

Problem No. On standard P.O.R. first problem identified is given No. 1 designation. This system is followed through on Objectives and Plans. On Life Skills Rehabilitation Section, Problem Numbers directly correspond to numbers on ABS. Item #2 on the ABS = Problem No. 2 on Master Problem List, etc.

On standard P.O.R. each new problem identified is written out, so each individual's P.O.R. is entirely different. On the Life Skills Rehabilitation Section, the same problems are listed for everyone within a particular level. Individualization occurs as results of the individual testing (A.B.S. are transferred to Master Problem List.)

Date Resolved. Indicates date problem resolved. For example, on 3/28/75, RBC signed off on Table Manners. This means RBC accepts responsibility for verifying the client has solved that problem.

Initial. Initial signifies problem solved; person who initialed assumes responsibility.

What does the Master Problem List look like?

See Volume III, p. _____.

2. **Experiential Exercise:**

Work in the same Mini-Team groupings. Continue with same three clients. If appropriate, you may want to include clients in this work session. You have transcribed the results of the ABS to the clients' Master Problem List. From the remaining list of Problems, choose three which you think are priority problems to be solved before the clients can move to a less restricted environment.

3. **Group Process:**

Critique your Team according to following criteria:

a. Everyone helped problem-solve.
b. Disagreements were resolved.
c. Meeting was problem-centered.
e. Team resources were maximized.
f. Other resources (consulting staff) will be utilized.
g. Obtain individual feed-back on your own role in team meeting. How did you see yourself? How did others see you?

1. **Discussion**

What do we do if the Problem is *not* resolved?

Suggested Responses

Show Slide #7-f.

Step 4: If the problem is not resolved, refer to the Life Skills Objective List. Set priorities and determine next objective to be met.

STEP 4. IF PROBLEM IS NOT RESOLVED, REFER TO LIFE SKILLS OBJECTIVE LIST. SET PRIORITIES AND DETERMINE NEXT OBJECTIVE TO BE MET.

EXAMPLE:

DATE	INIT	PROB #	OBJ #	LIFE SKILLS OBJECTIVE LIST Level I page 1	DATE RESOLVED	INIT
3/28/75	KBC	2	1	Order single item (coke) from soda fountain or canteen	3/28/75	KBC
3/28/75	KBC		2	order simple meal (sandwich and drink) at carry out or machine		
			3	order complete meal in restaurant or cafeteria		

Decide if any of the objectives within that Problem have been met. If you (Mini-Team) determine some objectives are already met, sign off on *Date Resolved.* If you have decided this is a priority Problem, initial the next objective. That signifies the problem has been identified and gives date for beginning to meet objectives. (See Volume III for complete Objective List, Level I.)

What if the Mini-Team decides this is not a very important problem?

Skip it for the present. Always decide upon *oriority* problems. What problems are keeping the client from functioning in the least restricted environment possible? Many of these problems can best be solved in a community setting.

Start on those problems which are holding client back in present environment. There is no point in teaching a client to order a meal in a public restaurant if (s)he is non-verbal, non-ambulatory, and cannot eat with a fork.

What do we do after we have met all the objectives for a particular problem?	Sign off on the Objective List first. Then sign off on the Master Problem List. Reinforce each other with congratulations. Let the client initial. Reward for success. Select new problem(s).
Is there a complete Life Skills Objective List?	Yes. See Volume III.

2. **Experiential Exercise:**

Work in Mini-Team groupings. Continue with the same three clients. Using A.B.S. results, set three priority problems for each. Use Objective List and establish objective for each Problem. Indicate time required to complete problem identification for one client. Keep some record of time to see if change occurs as Mini-Team works together, i.e., time for first client = _____. Time for second client = _____. etc.

3. **Group Process:**

Critique your Team according to following criteria:

a. Everyone helped problem-solve.
b. Disagreements were resolved.
c. Meeting was task-oriented.
e. Team resources were maximized.
f. Other resources (consulting staff) will be utilized.
g. Critiques yourself on the criteria above. Have other members of the team criticize you. Compare notes. Substitute "I" for "everyone" etc.

1. **Discussion**	**Suggested Responses**
Once we have established the Objective, how do we help prepare the client to meet that objective;	Show Slide #7-g. Follow the Life Skills Objective Plan which was designed to give a structured approach to meeting that specific Objective.

Life Skills Objective Plan

ABS Problem = 2 Eating in public
Objective = 1 Orders soft drinks

I. **MATERIALS**

Money

II. **SETTING**

A. Canteen
B. Community soda fountain

III. **MASTER INSTRUCTIONAL PLAN**

A. When possible, demonstrate performance or task
B. Observe resident perform task
C. Give positive reinforcement for successful attempt
D. Master each small step before continuing

Is there any rationale for the development of this format for the Life Skills Objective Plans?	Yes. The Life Skills Objective Plans are designed to: Establish a behavior modification approach to learning. Help staff realize that modeling may be most important method of "teaching." Help staff understand that learning takes place more appropriately in a realistic setting; i.e., toothbrushing is learned in a bathroom – not in a classroom. Help staff develop skills of observation. Help staff learn principles of reinforcement. Help staff learn to break down tasks into smaller units. Help staff learn to follow-up and continuously evaluate progress (or lack of same).
Why did you write out all of these Plans?	To carry through with the total Life Skills system based on the items in the A.B.S. To make it more convenient so staff would have one source to spot. To give guidance in structuring a learning situation. To give assistance and direction to staff who may not have expertise in curriculum development. To be sure everyone uses the same criteria check-list for deciding whether or not an objective has been met. To give staff an idea about materials needed to set up learning situation for particular skill. To build in accountability. If Objective Plan is available, no one can say they did not know what to do or how to go about it.
Is there a complete set of these Plans for Level I?	Yes. See Volume III.

2. **Experiential Exercise:**

Select a Problem or Objective that is not included on the Master Lists. Using the format for the Life Skills Plan, write your own Plan to meet the Problem or Objective you have designated. Work together in Mini-Teams.

1. **Discussion**

What are Life Skills Objective Charts?

Suggested Responses

The Life Skills Objective Charts were developed as a reinforcement system so that the Objectives could be displayed in appropriate areas where development of those skills would most likely occur.

Show Slide #7-h. This is an example of a Life Skills Objective Chart for Level I.

Life Skills Objective Chart
LEVEL I
Work Habits

AREAS FOR TEACHING: Work areas, recreational areas, living areas, classroom

STAFF RESPONSIBLE: V R Counselor, employer, residence workers, teachers, clients, etc.

ABS Problem No.	Objective 1	Objective 2	Objective 3	Objective 4
50 Job Complexity	performs job requiring use of tools			
51 Job Performance	does good careful work	works at adequate speed	takes care of tools & equipment	careful when working
52 Work Habits	on time to work or play	rarely absent from work	completes job on own initiative no complaints	asks permission to leave job station

Why is there a title "Work Habits" on this Life Skills Objective Chart?

The A.B.S. focuses on major categories of Life Skills. We grouped the A.B.S. Problems according to these major categories. These three Problems were selected for Level I (#'s 50, 51, 52).

What are the advantages of having these Life Skills Charts displayed in areas where the skills will be acquired?

The Charts are constant reminders to staff of the objectives of habilitation (or rehabilitation) for every client in that area. If they know what group goals are, they can more easily individualize their programming.

The Charts are designed to reinforce clients' awareness of training objectives. Charts for lower levels have paired illustrations with the written words so clients will direct attention to them.

Charts may be used on an individual level with clients in upper levels. Clients can post the charts and mark off objectives as they are met.

Objective Charts are designed to emphasize the concept that Life Skills are best taught in the area where it is most natural. This is the way children learn these skills in a "normal" home. They learn by modeling behavior of parents and siblings.

Objective Charts are designed to serve as a stimulus in the environment. When client is in the canteen, charts will remind both staff and client that certain skills are necessary in purchasing. They allow canteen staff to be part of the habilitation-rehabilitation process, rather than just being hired canteen employees.

The Charts will be displayed in all areas where clients need to be practising and learning Life Skills. Anyone working in any area can be part of the reinforcement system in helping clients develop skills needed to meet the objectives set for deinstitutionalization.

The Charts help reinforce the concept that Life Skills are taught all day, every day, in every area, by all staff. Note *Areas for Teaching Work Habits* on this Chart.

How does this Chart help with accountability?

At the top of each Life Skills Objective Chart there is a designated area for teaching the skills listed on the Chart. Under the heading, "Staff Responsible" the first staff listed will sign off on the P.O.R. for those particular skills. Others listed will support efforts exerted in meeting these objectives. In this way, certain staff will be ultimately responsible for

the development of certain skills. These objectives are selected according to areas in which they can best be met. For example, *care of clothing* should be taught in living quarters where care of clothing is a natural part of living. Staff who work in living areas should be responsible for teaching these skills. If it is an academic skill (telling time) it is best taught by trained special education teachers. It will need to be reinforced throughout the day in all areas where clocks are part of the environment. Each staff person is accountable for reinforcing efforts of others because each knows the objectives for the individual as well as for the group of clients.

If I am working with a client who needs some help with a Level II skill, will there be Objective Plans and Charts for these lower levels?

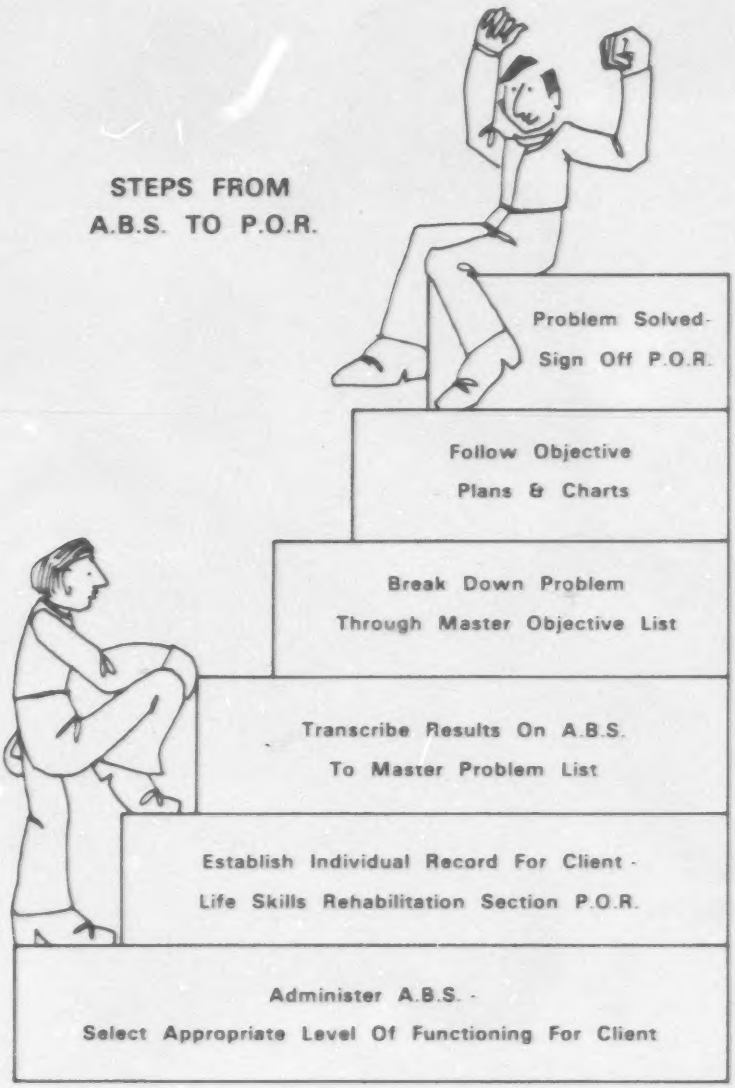
Yes. The complete package of training materials will be developed through the PORTLS Project next year.

Is there a complete set of these Charts for Level I?

Yes. See back cover.

1. Discussion	Suggested Responses
What do we do when a *Problem* is solved?	You and the client (when appropriate) sign off on the P.O.R. Reward yourselves. Congratulate yourselves and the client. Have the client mark it off on his/her individual Chart. Show it to other clients. Have the client say, "I am proud of my accomplishment."
What do we do next?	Have another Mini-Team meeting. Repeat the process. Back to Step One. Go!
What's the process?	Here's a review. Cheers!

Show Slide 7-I



ISSUE NO. 8. HOW DO WE KEEP SCORE IN THIS GAME?
STRATEGY NO. 8. ESTABLISH AN ACCOUNTABLE RECORD-KEEPING SYSTEM.

A. Pre-Post Test – Problem-Oriented-Record

Instructions: Fill in appropriate column with a check-mark (/)

	True	I think so	I don't know	False
1. The Problem-Oriented-Record (P.O.R.) is a method of record-keeping developed from the medical model.				
2. The P.O.R. can be based upon the A.B.S. scores.				
3. The P.O.R. helps us set goals for our clients.				
4. By using the P.O.R. we can see our progress with clients.				
5. The P.O.R. was developed by a physician.				
6. The P.O.R. system provides accountability for progress.				
7. The P.O.R. system does not require team effort.				
8. We are more likely to meet our goals when using the P.O.R. system.				
9. The P.O.R. allows everyone, including the client, to audit care.				
10. Goal-setting can be kept more current if done in small groups.				
11. The client should not be involved in his/her own treatment plan.				
12. The goal-setting method is a behavior modification approach.				

Scoring: See Appendix A

B. Introduction

One of the goals of the Life Skills Project was to assist Forest Haven in instituting the Problem-Oriented-Record keeping system in order to establish a system of accountability in record-keeping. The P.O.R. (we have omitted the *Medical* from the P.O.M.R.) is being adopted as the preferred system of record-keeping in many institutions because it offers a system of accountability and accessibility which old record-keeping systems do not have. In the past patient records have tended to be the information system for professionals only. Those staff people who were closest to the "patient" were often denied access to either reading or recording in the files. Records were most often kept by discipline rather than by the discipline's unique contribution to problem-solving for the patient.

The P.O.M.R., Problem-Oriented-Medical-Record, introduced by Dr. Lawrence L. Weed in 1962, changed the source or discipline structured method of record-keeping to one where all data was oriented around each problem of the patient. The concept has been extended from use by physicians to nurses and all health professionals.*

The P.O.R. system was the basis for the development of the Rehabilitation Section of the Life Skills Project. It offers a team-centered system in which responsibility for client progress is shared by all team members. Whereas goal-setting was formerly the role of a professional few, it now becomes the responsibility of all who come in contact with a client. In the past, responsibility was difficult to pin-point. Through the P.O.R., those who set goals are responsible for meeting goals.

We divided the Master Problem List and Master Objective List according to broad Life Areas and assigned staff who were best suited to assist with meeting these goals to be responsible. In this way, everyone knows who is responsible for what action. It is a supportive system because responsibilities are divided so that ultimate responsibility and reinforcement practices are shared equally.

We introduced the principles of goal-setting at the ward level before administrative staff requested institution of the P.O.R. system. In this way direct-care staff were already involved in decision-making and were not resistive to the idea when introduced by the management. In essence they were already setting goals, projecting deadlines for meeting these goals, writing plans, and accepting responsibility for meeting objectives. This put them in the same position as administrative staff, functioning with management by objectives. Accountability is built in through the record-keeping system which is subject to constant review, is accessible to everyone, including the client, and offers a system of reinforcement for both client and staff. Everyone knows where the "buck" falls and everyone knows when someone has been successful.

> . . . P.O.R. is a tool that unites all the health care disciplines to provide a logical way of recording patient care given, a method for auditing care, and a process for correcting discrepancies. Instead of compartmentalizing the patient's chart according to the information source – physician's notes,

---

*Department of Medicine and Surgery, Veterans Administration, Problem-Oriented Medical Record (P.O.M.R.) (Washington, D.C., 1974).

nurse's notes, lab reports – the P.O.R. system makes the patient and his problems central. And every observation, assessment, nursing plan, physician's order, or report of care or service given, whether by a physician, nurse, dietitian, or even a clergyman, has to be related directly to a problem."*

We feel the Rehabilitation Section of the Life Skills system has one important advantage over the standard P.O.R. system. Once the results from the A.B.S. are transferred to the Master Problem List, the client and staff are confronted with successes as well as with areas of deficiencies or problems. Sometimes even one success can be helpful in developing a more positive staff view of a client who has a multitude of problems. We believe we have built in a "Power of Positive Thinking" variable that may be helpful in changing attitudes toward clients who might seem poor candidates for deinstitutionalization.

---

*Alice M. Robinson, R.N. "Problem-Oriented-Record: Uniting the team for total care," *R.N.*, Volume 38, Number 6 (June 1975), pp. 23-24.

Bibliography

Aradine, C.R., and Guthneck, M. "The Problem-Oriented-Record in a Family Health Service." American Journal of Nursing, Volume 74, Number 6 (June 1974), pp. 1108-1112.

Bronkowsky, M. "Adapting the Problem-Oriented-Medical-Record to Community Health Care." Nursing Outlook (August 1972), pp. 515-518.

Gardner, William. A manual on program development in mental retardation. A.A.M.D. Project.

Gertzok, J. "The Changing Concept of Medical Records." Medical Record News. (June 1971).

Houts, P., Scott, R. Goal Planning with the Mentally Retarded: A Workbook.

Houts, P., Scott, R., and Leaser, J. Goal Planning with the Mentally Retarded. (Second Edition).

Hurst, J.W., and Walker, H. The Problem-Oriented System. MEDCOM, Medical Update Series: New York, MEDCOM Press, 1973.

Moriarity, Barbara. "Successful Goal Planning with the Mentally Disabled." The Social and Rehabilitation Record, Volume 1 (May 1974).

Phaneuf, M.C. The Nursing Audit: Profile for Excellence. New York: Appleton-Century-Crofts, 1972.

Problem-Oriented-Medical-Record. 1B 14-2. Washington, D.C.: Central Office Library, Veterans Administration, 810 Vermont. Bibliography of eighty (80) selected journal articles.

Problem-Oriented-Record Training Manual. Department of Mental Health and Mental Retardation. Commonwealth of Virginia.

Robinson, Alice, M., R.N. "Problem-Oriented-Record: Uniting the Team for Total Care." R.N., Volume 38, Number 6 (June 1975), pp. 23-28.

Spitzer, R.L. "Problem-Oriented-Medical-Record." International Journal of Psychiatry. (September 1973), pp. 376-379.

Taylor, D.B. A Clinical Information System: A Tool for Improving Nurses' Decisions in Planning Patient Care. ANA Clinical Sessions: 163, 1970.

"The Medical Record, Coverup or Teaching Tool?" Hospital Practice (July 1969), pp. 78-79.

Weed, Lawrence, J. Medical Records, Medical Evaluation, and Patient Care; The Problem-Oriented-Record As A Basic Tool. Cleveland, Ohio: Press Case of Western Reserve University, 1969.

Wesseling, E. "Automating the Nursing History and Care Plan." Journal of Nursing Administration (May - June 1972), pp. 34-38.

APPENDIX A. ANSWERS TO PRE-POST TESTS

#2 Adaptive Behavior Scale

True (1 through 10)
False (none)

#4 Role of Superintendent in Deinstitutionalization

Yes (1,2,5,6,7,10)
No (3,4,8,9,)

#5 Team Approach

Ideally, all answers should be marked "Always." #38 is one exception. If others are marked "Always," the answer here could be variable.

#7 Attitude Therapy

True (1,2,4,5,7,8)
False (3,6,9,10)

#8 Problem-Oriented-Record

True (1,2,3,4,5,6,8,9,10,12)
False (7,11)

APPENDIX B.

The Superintendent and Accountability
Roland J. Queene, M.Ed.
Superintendent, Forest Haven
The Residential Institution for District of Columbia, Laurel, Maryland

Regardless of what structure States may utilize in their system of services for the mentally retarded, you will find that the most crucial individual in this service network is not the State Director of Mental Retardation, not the Regional Director, not the Coordinator of Community Programs, not the Commissioner of Mental Health and Mental Retardation, but the Superintendent of a Residential Center. Although the significance of his role can be attributed to many factors – historical, social, and political – however, my comments today will revolve around a more proxemic view of the Superintendent.

Briefly, proxemics is a term coined by the anthropologist Hall (1966) for the interrelated observations and theories of man's use of space as a specialized elaboration of culture. In this paper I will attempt to convey a message based on distance and space as it relates to the accountability of the superintendent in the process of deinstitutionalization. To put it in simple language, my comments will be about the nature of the Superintendent and his relationship to his community.

Many articles have been written about superintendents and their role in facilities for the mentally retarded. Their reputations are almost legendary, and they are often described as tough-skinned and great liberators. The responsibilities of the superintendent can be summarized as follows:

(1) To work with boards of directors in defining the center's program and in making recommendations for policy changes as needed;

(2) To participate in the administrative functions of the central organization and to be identified with its goals;

(3) To establish personnel practices or maintain those of the central organization;

(4) To direct and coordinate problems relating to the budget, maintenance, and general management of the institution;

(5) To insure the maintenance of good standards of service and training through the coordination of administrative and clinical activities; and,

(6) To cultivate good community relations.

Although the above is an over simplification of an overwhelming job, one can say, that's the way it used to be. However, much to everyone's chagrin, along came deinstitutionalization, and the superintendent, almost overnight, saw his stock plummet to an all-time low. In short, he became the victim of scapegoat psychology. He was the culprit who was responsibile for warehousing and the dehumanization of mentally retarded persons. The attacks by the community and the unrest in the institution placed him in no-man's land. The superintendent became a "marginal man," one whom fate has condemned to work in two groups and in two, not merely different, but antagonistic philosophies. Superintendents occupy an ambiguous position, yet they are motivated to affiliate with both sides. As a result they are not fully accepted by either. This often develops into severe conflict because the accountability appropriate in the community and in the institution is antagonistic.

In achieving the kind of accountability that is essential for effective deinstitutionalization, superintendents should view their role as it relates to the retarded person, the family, the institution, the community and the government. (See illustration A, Spatial Components of the Superintendency.) Negating or excluding any one of these areas would create serious conflict in the deinstitutionalization process. We cannot afford a fragmented, going-no-where, uncoordinated approach in our efforts to improve life for persons who are mentally retarded.

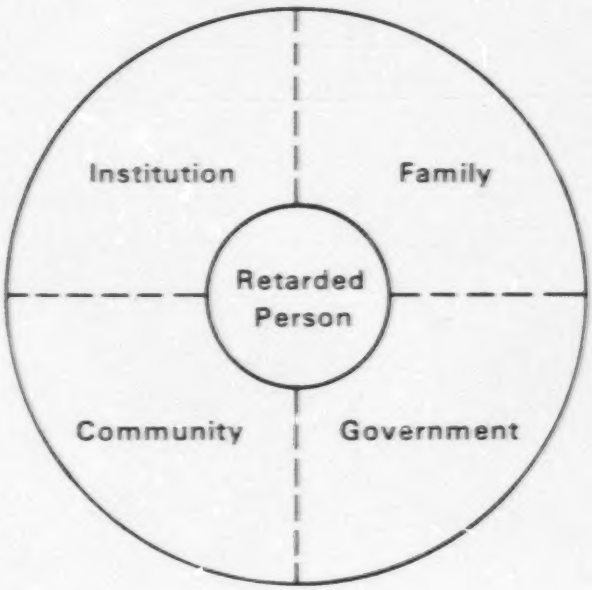
Illustration B gives an example of four components of accountability that the superintendent will need some expertise and competency in, if he is going to have some success in the thrust toward deinstitutionalization.

Let's take each of these components separately. In the 1970s effective planning is a must. The process of returning large numbers of mentally retarded persons to their communities is a very intricate and sensitive process. No option or maneuver should be left to chance. A superintendent must be omniscient and omnipresent. To clarify what I mean, please allow me to plagiarize on the three-pigs theme for a brief moment.

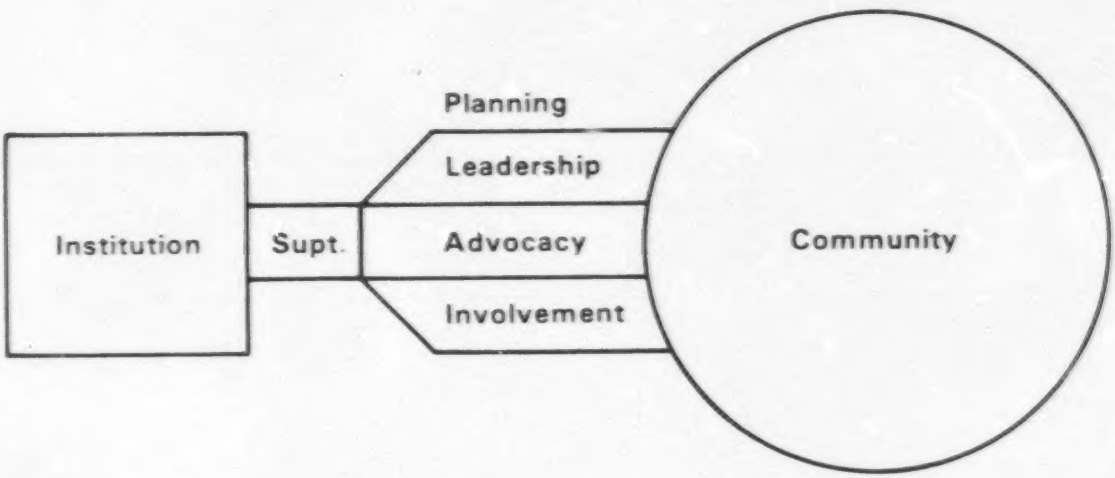
Once upon a time there were two superintendents (a third one had gone into industry and disappeared) who were faced with the problem of deinstitutionalization.

One superintendent was an old-timer in the community-institution business, and he saw the problem right away – just build a strong department of nursing and social services to resist the huffing and puffing he had experienced with the com..unity before. So the first superintendent built his community-resistant program right away out of genuine, reliable nurses and social workers.

A. SPATIAL COMPONENTS OF THE SUPERINTENDENCY



B. COMPONENTS OF ACCOUNTABILITY



The second superintendent was green at this deinstitutionalization business, but he was thoughtful. He decided that he would analyze the deinstitutionalization problem a bit. He sat down and drew up a matrix (which of course is superintendent's Latin for a big blank sheet of paper) and listed the problem, analyzed the problem into components and alternatives, listed the design objectives of deinstitutionalization, determined the functions that his institution should perform, designed and built his program, and waited to see how well it worked. (He had to be an optimist, for he had never been a superintendent before.)

All this time, the old-timer superintendent was laughing at the planner superintendent and emphatically declined to enter into this kind of folly. He had developed institutional programs before, and he had lived and prospered, hadn't he? He said to the planner superintendent, "If you know what you are doing, you don't have to go through all that jazz." And with this he went fishing and golfing, or whatever it is that superintendents do in their idle hours.

The second superintendent worked his system anyway and designed for predicted contingencies. One day a delegation consisting of the State Board, the Association of Retarded Citizens, the Commissioner and some politicians visited the two institutions (they both looked the same – after all, an institution is an institution). They walked through the first superintendent's institution and uttered a warning to the old-timer which was roundly rejected, as usual. With this, the delegation, instead of huffing and puffing, pulled out a letter of resignation and handed it to the first superintendent, and the poor old-timer was gone.

Still not satisfied, the delegation walked to the planner superintendent's institution and repeated the act. However, the second superintendent displayed a program of deinstitutionalization and institutional reform which left the delegation flabber-gasted. They left and were never heard from again.

Morals:

(1) They are not making delegations like they used to;
(2) It's hard to teach old superintendents new tricks;
(3) If you want to keep the delegation away from your institution, you'd better deinstitutionalize.

Judging from the above remarks, I feel that the planning component requires no further discussion.

Leadership and its affiliation with superintendents has been kicked around for years. Many of us can recall articles, testimonies, and even poetry about the leadership capabilities of superintendents. However, when deinstitutionalization is mentioned, the voice of the superintendent is unheard. In fact, he is evident by his absence. In less than a decade ago no State would initiate a program for the mentally retarded unless the superintendents gave it the green light. My cry, today, is, where are you, superintendents?

The kind of leadership that is required of superintendents in reducing the population in our centers can best be illustrated by Rev. Jesse Jackson, Director of People United to Save Humanity, who speaks of two kinds of leadership. One type is called the *tree shakers* – those who overtly and aggressively attack problems for the purpose of causing something to happen. He calls the other the *jelly makers* – those who, after an awareness and need have been exposed, take considered steps to organize consensual solutions. Both types are supportive; however, what we need are more *tree shaking* superintendents. The superintendent who stands in the vanguard of deinstitutionalization does not require pushing or pulling. What he needs are followers.

To carry out the goals of deinstitutionalization, the superintendent must assume the role of advocate. His voice has been heard in many state assemblies across the country, asking for funds to improve the

quality of life in our institutions. Yet, that voice is mysteriously quiet when it comes to asking for those items that would facilitate the residents' return to the community.

The superintendent must at all cost and at every opportunity protect the rights and dignity of retarded persons. His vigil should be one of constancy and invincibility. To overcome deeply embedded attitudes about retarded persons, there is needed a program of education and public information far different from the public relations experienced in yesterday's institutions.

Occurring simultaneously with the attitudes that developed about the mentally retarded were certain attitudes about the superintendent. Let me paraphrase Desmond Lawrence (1969).

Step 1 – "Look at the superintendent keeping that poor retarded child in the institution."

Step 2 – "That superintendent is vicious."

Step 3 – "All superintendents are vicious."

Step 4 – "Superintendents will dehumanize anyone."

Step 5 – "There is another superintendent. Dehumanize him before he dehumanizes you."

Step 6 – "There you are; that proves it. Superintendents are vicious."

Step 7 – "Hit all superintendents."

My friends, superintendents must be advocates for the mentally retarded residents in the institution as well as the office of the superintendent in that same institution.

To introduce the final component of accountability, the following statement by Henry Miller (1962) should be noted.

> "Supposing that we all considered ourselves members of, not an organization but an ancient, durable order, the only one we can truly give allegiance to – *humanity*. Supposing that, instead of blame and censure or judgment and punishment, we met deviations and aberrations of the norm with sympathy and understanding, with a desire to aid rather than a desire to protect ourselves. Supposing we based our security solely upon the certitude of mutual aid. Supposing we scrapped the web of complicated laws in which we are now hopelessly enmeshed and substituted the unwritten law that no cry of distress, no appeal for help should go unnoticed. Is not the instinct to aid one another just as strong, stronger indeed, than the impulse to condemn? Do we not suffer from the disuse of this instinct, from its usurpation by the state and charitable organizations of every kind? Are we not all victims of fear and anxiety precisely because we lack faith and trust in one another?"

The concepts of alienation, relevance and involvement are much discussed terms in our present day society. It seems, however, that more time is indulged in the former and less substantive than in the latter. We say we are involved, yet our involvement is only a vascillating rhetoric imparting little or nothing. For superintendents, being accountable for community involvement is the Rolls-Royce of deinstitutionalization. It is, as Miller suggested, "a desire to aid rather than a desire to protect ourselves." This is really what *involvement* is all about.

In concluding my remarks, it is safe to say that deinstitutionalization is upon us. We look around and we see community disorganization and institutional disorganization. Criticism of one entity or the other is the topic of every street-corner rap. We can say with assurance, however, that by the time a foolish superintendent learns the game the players will have dispersed. The superintendent must realize that he is

the quarterback of deinstitutionalization. We know that when the quarterback is playing a bad game he is going to catch hell. Superintendents, get your game together. For if you wait until tomorrow to play the game, the game is going to be twice as difficult.

One parting thought for the concerned and accountable superintendent is the proxemic nature of his function. Separation, segregation, or integration are not the roads to deinstitutionalization. The modes of operation are amalgamation, the process of unification, comingling and intermingling. This is where the action is. And in the words of the late Walter Lippman (1974):

> ". . . it is a time of opportunity. It is a cruel and bitter time for those who are the present victims of disorder. But for the young and those who are free in spirit it is a time of liberation and of opportunity. For them there remains, come what may, their own energy, and the richness of the earth, the heritage of invention and skill and the corpus of human wisdom. They need no more. Their paths will be more open, and what in one light is a vast breakdown of hopes is in another light the clearing away of debts and rigidities and preemptions that would choke them on their way."

To all superintendents I extend my warm wishes for a long life of work, health and happiness.

Bibliography

Hall, Edward T., The Hidden Dimensions, Doubleday and Company, New York, 1966.

Miller, Henry, Stand Still Like the Hummingbird, New Director Publishing Co., New York, 1962.

Morris, Desmond, The Human Zoo, McGraw Hill Book Co., New York, 1969.

Lippman, Walter, "A Time of Opportunity," The New Republic, December 28, 1974.

Source: Roland J. Queene, M.Ed., "The Superintendent and Accountability," Deinstitutionalization: A Service Continuum (Published by Developmental Disabilities Councils of West Virginia and Virginia in cooperation with Region III, HEW Developmental Disabilities Council Consortium, February 1975), pp. 97-105.

APPENDIX C.

Dimensions of Managerial Behavior

Richard L. Burke, Ph.D., University of Houston
Philip G. Hanson, Ph.D., V.A. Hospital
Houston, Texas

Person *being* rated: _____ Date: _____

Person *doing* rating is my (check one):

____ Supervisor (or higher position in organization)
____ Subordinate (or lower position in the organization)
____ Colleague (Peer)

INSTRUCTIONS: This form has been designed for feedback purposes, to assist the person being rated to focus more clearly on managerial or supervisory behaviors which will help him increase his effectiveness.

In completing each numbered item for the individual being rated, place an "M" at the alternative which is **Most** like that individual's managerial behavior – which most applies to his usual style. Place an "L" at the statement which is **Least** like his typical managerial behavior, as you know him – which he seldom or never does. Put an "M" *and* "L" in each section.

Wherever possible, please give examples or further explanations of his managerial behavior, as you have seen it, in the space indicated.

1. LISTENING:

____ Blocks other people out; quickly rejects others' ideas
____ Sometimes listens and sometimes doesn't; pays attention to majority viewpoint
____ Hears words but not feelings behind them
____ Draws other people out; interprets communication from sender's point of view
____ Gives little indication that he's involved or hears what is said
____ Very sensitive to other people's feelings and personalities

Examples and comments:

2. EXPRESSING IDEAS TO OTHERS:

____ Feels he's right; pushes own ideas regardless of reactions
____ Expresses own ideas fully *and* encourages others; checks whether he's understood
____ Expresses ideas logically and clearly; sticks to facts
____ Holds back; doesn't try sufficiently hard to get his own ideas across
____ Sometimes pushes own ideas and sometimes holds back
____ Encourages others to express *their* ideas; concerned with reactions to him

Examples and comments:

3. INFLUENCE STYLE:

____ By delegating influence to others and then staying out of it
____ By involving others in the issue; working as a team
____ By status and position, or by using rewards and punishments
____ By weight of ideas and logic
____ By sensing majority opinion and going along with it
____ By being friendly and supportive

Examples and comments:

4. DECISION-MAKING:

____ Focuses primarily on keeping subordinates happy and morale high
____ Settles for safe, reasonable compromise between productivity and morale
____ Focuses primarily on getting job done without regard for others' feelings
____ Gets job done through getting people, including himself, involved as a team
____ Believes in making important decisions by himself
____ Leaves others to make their decisions and then goes along with them; follows lead of other people

Examples and comments:

5. RELATIONSHIPS WITH OTHERS:

____ Works best as a "loner"; won't take sides where differences exist
____ Is very involved with others; keeps subordinate involved
____ Expects subordinates to follow his lead and support him
____ Sees need for supporting others; sometimes supports others right or wrong
____ Maintains distant, cool relationships; focuses primarily on task issues
____ Encourages compromises among fellow workers or group

Examples and comments:

6. TASK ORIENTATION:

____ Constantly pressures to get job done; practices close supervision
____ Sees task goals and morale as both very important and fully attainable
____ Encourages task accomplishment to avoid pressure from above
____ Seems uninvolved with task; has difficulty in meeting deadlines
____ Concentrates energy on task as deadlines approach; works by crisis
____ Distinguishes clearly between important and unimportant tasks; works methodically

Examples and comments:

7. HANDLING OF CONFLICT:

____ Works with conflict openly and productively; sees conflict as potentially useful
____ Doesn't respond to conflict; sees conflicts as insoluable
____ Goes out of way to avoid conflicts; smoothes over conflicts for sake of harmony
____ Tries to manage people's feelings sufficiently to get adequate commitment and productivity
____ Wants issues decided strictly on merit, keeping feelings and personalities out
____ Engages in conflict with a personal need to complete and win

Examples and comments:

8. WILLINGNESS TO CHANGE:

____ Values opinions and suggestions of others more when they don't conflict with his own
____ Tries new things only if he thinks of them himself; hard to influence
____ Quick to utilize subordinates' ideas because *they* need to feel successful
____ Sees little value in worrying about change and innovation; sees little likelihood of bringing about change
____ Considers ideas thoroughly before committing himself to something new
____ Considers new ideas and is open to being influenced; works with team in coming up with new ideas

Examples and comments:

9. PROBLEM-SOLVING:

____ Considers suggestions from others and then makes final decisions himself
____ Solves problems in group by encouraging all relevant ideas and reactions; works for consensus solutions
____ Conducts problem-solving meetings as informal "bull-session"; stresses happy atmosphere
____ Considers all pertinent facts and information; rules feelings out
____ Slows down groups by going off on tangents and telling anecdotes
____ Sets his own directions and keeps them in mind; blocks out interruptions

Examples and comments;

10. GOAL-SETTING:

____ Believes his own goals are the most appropriate ones; nets goals and directions for subordinates
____ Works toward safe balance between organizational directives and subordinates' needs
____ Sets goals in work group as a team effort, stressing integration of organizational requirements
____ Goes along with goals set by others; follows line of least resistance
____ Follows goals from above as impersonal directives
____ Encourages subordinates to set their own objectives; emphasizes and supports their needs more than organizational needs

Examples and comments:

11. MOTIVATIONAL INCENTIVES:

____ Praises subordinates' efforts; works toward close and informal group climate
____ Tries for "hands-off" policy, feeling that most rewards won't affect subordinate performance
____ Encourages team effort in making job more stimulating and rewarding, while increasing effort
____ Uses combination of economic rewards and incentives with some encouragement and involvement of people
____ Is impersonal, following logical yardsticks and clear performance criteria in rewarding performance
____ Follows "carrot and stick" approach in rewarding individual performance; is very critical when people don't do things his way

Examples and comments:

12. SELF-DEVELOPMENT:

____ Asks for feedback or suggestions from others but doesn't seem to change much
____ Eager to know what to do to improve his staff relations, have a more friendly atmosphere

____ Sees problems more in others than in himself; seeks better subordinates
____ Is very analytical in studying his own performance; tries to become more logical and less emotional
____ Encourages comments on his behavior from others and considers this feedback fully
____ Doesn't seem to realize how others see him; discourages feedback

Examples and comments:

Source: Richard L. Burke, Ph.D. and Philip G. Hanson, Ph.D., "Dimensions of Managerial Behavior," Human Interaction Training Laboratory, V.A. Hospital, Houston, Texas. 1972

EXPLANATION OF STYLES OF INFLUENCE (Taken from Houston Conference)

Style of Influence	Grand Total	Rank Order
Democratic (HH)		
Moving Target (MM)		
Autocratic-Detached Critic (HL-DC)		
Autocratic-Tough Battler (HL-TB)		
Peace Maker (LH)		
Laissez faire (LL)		

(Line these up in rank order of styles you obtained on rating sheets to determine your primary and back-up styles of managerial behavior)

Democratic Style: Leadership style is function of task you are working on. Leadership gets distributed according tc who has best resources at the time. Leader is not all things to all people. Important thing is to find who has the best resources. With democratic style you can care about the task and the people at the same time.

Moving Target (MM): Fluctuates between autocratic and peacemaker. In a crisis the leader moves toward autocratic – then moves back toward peacemaker. Management by crisis style. Decision making is majority support – tends to cut off discussion. If group comes up with five decisions leader says, "Let's vote." When minority is outrated their support is questionable. They just put out fires. Leader may use this style when feeling situation out.

Autocratic-Detached Critic (HL-DC): Says, "I want to be very objective" and then makes the decision. Uses more subtle control. Rewards for what he wants and withholds support if he doesn't get it.

Autocratic-Tough Bettler (HL-TB): Comes in with his mind already made up and pushes through his decision. Defensive management. Particularly difficult when this person sees themselves as a benevolent dictator. Has an overprotective mother syndrome ("I take care of my people"). Feels people are disloyal because they don't understand his motives since he feels he always knows best.

Peace Maker (LH): Low concern for the task. Pours oil on troubled waters. Withholds negative feedback. Supports goals but avoids conflict. Says, "You know best – you be the leader." Inclined to feel people don't appreciate him/her.

Laissez faire (LL): Decisions just lie on table ("plop" decisions). Not much feedback. Lack of involvement, May be an autocratic trying to change so he overshoots and becomes laissez faire. If group fumbles, he can say, "See, I told you-you need a strong leader."

Appendix C-2. **DATA FEEDBACK SHEET 1**

1. Listening

Style	Tally
HL-TB	
MM	
HL-DC	
HH	
LL	
LH	

4. Decision-Making

Style	Tally
LH	
MM	
HL-DC	
HH	
HL-TB	
LL	

7. Handling of Conflict

Style	Tally
HH	
LL	
LH	
MM	
HL-DC	
HL-TB	

10. Goal-Setting

Style	Tally
HL-TB	
MM	
HH	
LL	
HL-DC	
LH	

	TOTAL
HH	
MM	
HL-DC	
HL-TB	
LH	
LL	

2. Expressing Ideas to Others

Style	Tally
HL-TB	
HH	
HL-DC	
LL	
MM	
LL	

5. Relationship with others

Style	Tally
LL	
HH	
HL-TB	
LH	
HL-DC	
MM	

8. Willingness to change

Style	Tally
MM	
HL-TB	
LH	
LL	
HL-DC	
HH	

11. Motivational Incentives

Style	Tally
LH	
LL	
HH	
MM	
HL-DC	
HL-TB	

	TOTAL
HH	
MM	
HL-DC	
HL-TB	
LH	
LL	

3. Influence Style

Style	Tally
MM	
HH	
HL-TB	
HL-DC	
LL	
LH	

6. Task Orientation

Style	Tally
HL-TB	
HH	
LH	
LL	
MM	
HL-DC	

9. Problem-Solving

Style	Tally
MM	
HH	
LH	
HL-DC	
LL	
HL-TB	

12. Self-Development

Style	Tally
MM	
LH	
LH-TB	
HL-DC	
HH	
LL	

	TOTAL
HH	
MM	
HL-DC	
HL-TB	
LM	
LL	

APPENDIX D.

Guidelines for Leadership Role
Geneva S. Folsom, Ed.D

1. The team leader should be comfortable in the role. Top executives, or high status personnel, do not always make good team leaders because the authoritarian role is not suited for the team leader role.

2. The team leader should be the best advocate for a particular client. It should be a rotating role. In this way, the team remains client-centered and problem-centered rather than power-centered.

3. All decisions re Life Skills goals and objectives should be based on the democratic process. One of the pitfalls and misinterpretations of this concept occurs when people interpret the democratic process as a popularity contest or follow the herd without thinking. Opposition should be heard. The goal is to arrive at complex decisions that serve the best interests of the client; it is not to keep friction down in the team meeting.

4. When the leader takes a "vote," everyone should understand what they are voting on and the outcome of the vote. Voting can be confusing. The leader must be skilled in active listening in order to obtain accurate feed-back from the group.

5. In the role of an active listener, it is the leader's function to understand the implications of "wandering" communication. What is happening with the group when new subjects are introduced before old issues are settled? The leader has to make decisions of when to step in and remind the group of the issues without ignoring what the group is really trying to communicate.

6. As the leader, you need to see that all opinions and ideas are expressed before you offer your opinion. The skilled leader should be the integrator, rather than an opinion-giver.

7. The leader must not be afraid of dissent. Disagreements are healthy and, when resolved, can lead to more thoughtful decisions. Creative problem-solving allows for exploration of alternatives and priorities.

8. The leader's enthusiasm and general attitude set the whole tone for any group. If, by verbal or non-verbal communication, the leader seems to truly believe the group is vitally important in decision-making, the team concept will be effective. Nothing can kill this effort more quickly than the leader who gives the impression that (s)he is just waiting until everyone has had their say before (s)he summarizes and makes arbitrary decisions.

Source: Compilation of Training Materials (Tuscaloosa, Alabama: Bryce Hospital, 1970, 3 pp.)

Appendix E. **Administering the A.B.S. Using Two Raters (In the Same Booklet)**

Jean Federici, The Life Skills Project / Field Instructor

1. Use a color code to distinguish between raters. For example: "Rater I" uses regular pencil, "Rater II" uses red pencil.

2. Fill out the cover of the A.B.S. booklet. Where it says: "Name of person filling out Scale" _____ _____. Each rater should include his/her name on this line in the color code he/she is going to use to rate the remainder of the booklet.

3. When administering the test, Rater I's pencil mark should go inside the circle provided and Rater II's red pencil mark should go to the right (or outside) of the circle.

4. To insure a more valid evaluation of a resident, the second rater should cover the answers of the first rater with a thin strip of paper.

PART ONE

There are two types of items in PART ONE:

The first type of item is developmental and each individual skill is given a numerical rating beginning with zero.

1. The rater should circle the number corresponding to the highest skill the resident can perform and then transfer this number to (or outside) the circle.

The second type of item is set up in check list form.

1. The rater checks the items applying to the resident being tested.
2. The rater totals the number of checks made and places this total in (or outside) the circle
3. When a check list item has an arithmetic problem over the circle; Total the number you checked and subtract this from the number given over the circle. For example:

/_	4 - number	
_	checked =	(4-3=1)
/_		
/_	1	

You simply subtract the number of check marks from 4.

4. When you encounter an arithmetic problem over a circle and decide not to check any items because they don't apply to the client being tested, check "None of the above."

"None of the above" is another way of saying zero (0), so you would figure the arithmetic problem using zero. For Example:

_	4 - number	
_	checked =	(4-1=4)
_		
_	4	
_		
None of the above /_		

PART TWO

There is only one type of item in PART TWO:

Each behavior listed in this section is followed by a number "1" and a number "2".

1. If a behavior is exhibited occasionally, circle the "1". 1
2. If the behavior is exhibited frequently, circle the "2". 2

STEPS FOR SCORING THE ADAPTIVE BEHAVIOR SCALE

Part One Page 3

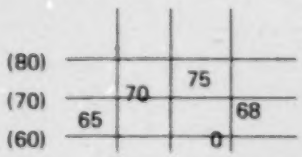
1. Add the numbers contained in each circle (0) and place the total in the triangle (Δ) provided at the end of each subdomain.
2. Transfer the score contained in each triangle (Δ) to its corresponding triangle (Δ) on the DATA SUMMARY SHEET for PART ONE. (There are two DATA SUMMARY SHEETS - use only one for each rater's set of scores).
3. Total the triangle (Δ) scores on the DATA SUMMARY SHEET and place the sum in the rectangle (▭) provided. This gives you the total score for that domain.
4. Transfer the total score for each domain to the PROFILE SUMMARY graph for PART ONE. (There are two PROFILE SUMMARY GRAPHS - use only one for each rater's set of scores). Place each score under its appropriate domain in the space marked "Attained Scores."

Part Two Page 12

1. Add the numbers contained in each circle (0) and place the total in the rectangle (▭) provided at the end of each section. The number contained in the rectangle (▭) is the domain score.
2. Transfer these scores contained in the rectangles to the DATA SUMMARY SHEET for PART TWO (next to their appropriate domain).
3. Transfer the total score for each domain to the PROFILE SUMMARY graph for PART TWO. Place each score under its appropriate domain in the space marked "Attained Scores."

GRAPHING PART ONE AND PART TWO OF THE A.B.S.

1. Compute age.
2. Fill out the information at the top of the PROFILE SUMMARY graph.
3. Using the A.B.S. Manual (1974) revision), turn to the Percentile Ranks (page 17) and locate the table corresponding to the age of the client being tested.
4. Find the "Attained Score" number in each domain of the Manual's Percentile Table.
5. With your finger on the "Attained Score" number in the Percentile Table, move to the left to determine the percentage.
6. Place this percentage in its appropriate domain of the PROFILE SUMMARY graph and circle it.
   Example:



7. Connect each circle percentage with a line when you have finished plotting the percentage for each domain.

*** Special Note for PART TWO:
When you are working with an "Attained Score" of zero, plot this on the zero (0) line of your PROFILE SUMMARY graph.

Appendix F.

TASK FORCES

Special thanks is extended to members of the following Task Forces, for their contributions to the Life Skills for the Developmentally Disabled Project.

TASK FORCE NO. 1 – LIFE SKILLS INSTITUTIONAL MATERIALS (LSIM)

Jean Ackerman	Children's Achievement Center – Perceptual Motor Spec.
Mary Jane Billinger	Northern Virginia Training Center
Betty Brooks	Planned Parenthood – Education
Dave Burket	Forest Haven – Education
Randy Swisher	G.W.U. Recreational Therapist – Student
Kali Mallik	G.W.U. Movility Project
Hilda Fishback	D.C. Bureau of Rehabilitation Services, Vocational Rehabilitation
Leonard Allen (Ad Hoc)	D.C. Mental Health Administration

TASK FORCE NO. 2 – LIFE SKILLS GENERAL MATERIALS (LSGM)

Karen Littman	The Maryland National Capital Park and Planning Commission
Maurice Brubaker	D.C. Developmental Services Center
Jackie Hendrick	Consumer – Developmental Disabilities Council
Sandra Fromm	Consumer – Developmental Disabilities Council
Jean Schreiber	Department of Human Resources, Placement of Developmentally Disabled
E'lise Brown	Sharpe Health School
Rosalie Ingenito	G.W.U. Rehabilitation Medicine

TASK FORCE NO. 3 – LIFE SKILLS COMMUNITY MATERIALS (LSCM)

John Noone	Georgetown, University of Affiliated Facility
Raymond Terry	D.C. Children's Center
Mark Kravick	D.C. Children's Center
Aretta Moore	Occupational and Training Center
Eveline Schulman	Maryland Department of Retardation
Helen Jo Hillman	D.C. Department of Recreation
Shirley Zamora	American Occupational Therapy Association

TASK FORCE NO. 4 – FOREST HAVEN TASK FORCE

Dave Burket	Acting Chief of Habilitation Services
Frances Greene	Training Instructor
Jean Federici	Activity Therapist/Field Instructor – Life Skills Project
William Cheek	Principal, Mary Ziegler School
Charles McCullum	Vocational Rehabilitation Counselor
Walter Spann	Director of Cottage Life
Maureen Lombardo	Speech Pathologist
John Ross	Special Education Teacher
Hobart Goins	Special Education Teacher
Emma Hendricks	Resource Teacher
Roma Kaplan	Chief of Volunteer Services

Appendix G

Instructional staff at Northern Virginia Training Center is responsible for this revision of the graphic representation of the Training Model. Since it expresses the total philosophy in the Manual for Trainers, their feed-back was greatly appreciated. "Thanks" to Anita Auerback, Beth Pittard, Mary Jone Billinger, Karen Percy, and Sheila Wolfe. Myra Feldman translated the idea from our team effort.

TRAINING MATERIALS	COST
Volume I	$2.00
Volume II	2.00
Volume III	2.00
Videocassattee (3/4 inch U-matic) to accompany Volume II	
Mini-Team	$35.00
Training Model	35.00
Communication Systems	35.00
Life Skills System – ABS to POR	35.00
Total package (4 tapes)	102.50
Slides to accompany Volume II (35 mm.)	
(package of 21 slides)	15.75
Objective Charts – Volume III	dependent upon quantity

Mailing charges will be added. Prices subject to change without notification.

To purchase training materials, order from:

Geneva S. Folsom, Ed.D.
The George Washington University
Division of Rehabilitation Medicine
2300 Eye Street, N.W.
Washington, D.C. 20037